GISAP:

MEDICAL SCIENCE, PHARMACOLOGY

International Academy of Science and Higher Education
London, United Kingdom
Global International Scientific Analytical Project

№12 Liberal* | March 2017

GISAP
MEDICAL SCIENCE, PHARMACOLOGY

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GISAP: Medical Science, Pharmacology №12 Liberal* (March, 2017)

Chief Editor – J.D., Prof., Acad. V.V. Pavlov

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ISSN 2053-7751
ISSN 2054-0795 (Online)

Design: Alexander Stadnichenko, Anastasia Onyskiv, Inna Shekina, Yury Skoblikov

Published and printed by the International Academy of Science and Higher Education (IASHE)
1 Kings Avenue, London, N21 3NA, United Kingdom
Phone: +442071939499, e-mail: office@gisap.eu, web: http://gisap.eu

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Print journal circulation: 1000

"*Liberal – the issue belongs to the initial stage of the journal foundation, based on scientifically reasonable but quite liberal editorial policy of selection of materials. The next stage of the development of the journal ("Professional") involves strict professional reviewing and admission of purely high-quality original scientific studies of authors from around the world".

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REHABILITATION PROGRAM FOR CHILDREN WITH BIRTH TRAUMA OF THE BRACHIAL PLEXUS

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Medical University, Bulgaria

Birth trauma of the brachial plexus is most often caused by difficult delivery of a large neonate. The data on the so-called obstetrical paralysis is scarce and controversial. In current life conditions and development of the medical science the number of children with plexus brachialis plexitis is supposed to decrease, but still this injury is present. The purpose of the study is analysing the results of the conducted complete one-year rehabilitation program for children with birth trauma of the brachial plexus, at the Clinic of Physical and Rehabilitation Medicine at the University Hospital Pleven. The study covers 24 children with the birth trauma of the brachial plexus, aged from 10-days old newborns to 13 years old children, who passed the complete rehabilitation program during the entire 2015; the program includes paraffin application, remedial massage, kinesitherapy, electrical stimulation, electrophoresis with Nivalin, labour therapy, occupational therapy and everyday life activities (for children over 5). Inquiry among parents, with open and standardized questions, is conducted. For good results from rehabilitation of children with the birth trauma of the brachial plexus the early diagnostics and initiation of the complete rehabilitation program are of crucial importance. Good results come hard and slowly, but the quality of life and work of the traumatized children is significantly improved.

Keywords: birth trauma, rehabilitation, everyday life activities, occupational therapy.

Conference participant,
National championship in scientific analytics

http://dx.doi.org/10.18007/gisap:msp.v0i12.1605

Introduction

Birth trauma of the brachial plexus is most often caused after hard delivery of a big infant, at breech presentation or other abnormal infant presentation, unsuccessful manipulations with forceps and vacuum extractors, narrow pelvis of the mother or raised tone of perineal muscles, congenital anomaly of infant's spinal column etc. [1].

Data on frequency of Erb's palsy are scarce and contradictory, and the reasons for this are explicable. According to the data provided by Gacheva, Y. (1982) the annual birth traumas in the country are between 320 and 380, which is 0,27% of all the newborns [1]. In present day conditions of life, with increased number of operative deliveries in risk pregnancies and the existing demographic collapse (annual decrease of number of newborns) we expect the decrease in number of infants born with the brachial plexus trauma. According to statistical data of the National Statistical Institute, in 2015 there were 66 370 children born in Bulgaria, but we haven't found any statistics on the number of children diagnosed with the Erb's palsy of the brachial plexus [7].

The fact that the brachial plexus is in close proximity to specifically moving structures of the shoulder girdle (fig. 1) is a prerequisite for traumatic injuries due to direct trauma (pressing) and stretching of nerve fibers in the area of the supraclavicular axilla (upper type injury), and in the area of axilla (lower type of injury) [3].

The disease is diagnosed mainly through anamnesis, applying various reflex and manual tests, and Rö-graphy – to exclude other pathology (clavicle fracture) [1]. In order to establish the damage degree and the level of injury, in the context of the modern medical diagnostics, the EMG is produced.

The clinical picture is typical for peripheral paresis or upper limb paresis, depending on the severity and the level of injury. Two main types of upper limb dysfunction are distinguished: upper type (Duchen-Erb), lower type (Dejerin-Klumpke) and total type. The paresis causes full or partial immobility of the limb [2]. As the child grows up, all structures of the upper limb show the delayed development (muscle hypotrophy and hypotonia, shorter limb, often spinal bending – scoliosis to the direction of the parenthetical limb). With age significant difficulties in performing everyday activities appear, as well as the diminished capacity for work [10].

Neuropraxia (neuropraxia) is a lower level of injury; treatment is mostly conservative and is performed by a team of specialists. In severely traumatic conditions total disruption of axons or nerves is found (axonotmesis, neurotmesis) [3].

Along with medicament treatment (anti-swelling therapy, Nivalin – subcutaneously as per schedule etc.), it is very important to place the injured limb in suitable orthosis for the positional therapy. Main role in the treatment of such an injury is played by the physical and rehabilitation medicine; during the age periods of growing the means vary, being individually selected and dosed [8].

While growing, the child (especially in case of severe, total injury) is examined by an orthopedist, in order to detect possible corrective operative interventions to facilitate self-service skills and to improve the patient's life quality. In 2012 Assoc. Prof. PhD M. Kateva, MD, head of the 1st Clinic of Traumatology at the „N.I. Pirogov" University Hospital in Sofia, with the help of Prof. Edgar Bimer organized the first course on microinvasive neurosurgery on arms, including the early operative treatment of birth traumatized plexus brachialis. This was the beginning of new surgery for the world as well, and the aim was to save children with injures on upper limbs that lead to full disability [12].

Objective of this study is analysis of results of a one-year complex rehabilitation programme for children with birth trauma of plexus brachialis, conducted in the Clinic of Physical and Rehabilitation Medicine at the University Hospital – Pleven.

Materials and methods

Twenty-four children with birth trauma of the plexus brachialis, aged between 10 days and 13 years (15 boys and 9 girls) are included in the study; the rehabilitation is conducted in the Clinic of Physical and Rehabilitation Medicine at the University Hospital – Pleven. From all monitored patients, 11 have injured right plexus brachialis, and 13 have

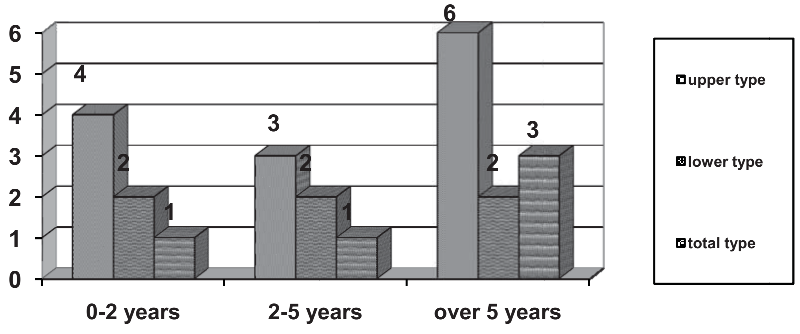

Fig. 1. Distribution of observed children by type lesion and age groups

the left limb injured. The diagnostics is performed through the clinical neuro-physiological test, based on transitional unconditional motor reflexes [1]. 16 children have Duchen-Erb type injury (upper + middle – $C_{5,6,7}$), 3 – Dejerin-Klumpke (lower type – $C_{7,8}$ – Th_1), and the rest 5 have total injury of plexus brachialis ($C_{5,6,7,8}$ – Th_1). The allocation of children in age groups (0–2 years old; 2–5 years old; over the age of 5) and the injury type are displayed on fig. 1. The graph shows the prevalence of traumas of the Duchen-Erb type, followed by total injury.

In compliance with the National Frame Contract for 2015 the Health Fund provides for a 10-day rehabilitation programme, following a clinical path relevant to the age of the children with birth trauma of the brachial plexus – 12 rehabilitation courses annually (each month) for children aged 0–24 months, 4 rehabilitation courses annually for children aged 2–5, and 2 rehabilitation courses annually for children over the age of 5 [6]. Grown up children with the Erb’s palsy can visit additional rehabilitation courses without limitations, but on ambulatory basis. The average number of completed rehabilitation courses (totally through clinical path and ambulatory) conducted over the one-year period we monitored is displayed on fig. 2; the children are allocated in age groups.

All children with the birth trauma of the brachial plexus participated in a complex rehabilitation programme for 10 consecutive days, dosed suitably for their age and that included: paraffin applications; healing massage; kinesiotherapy; electrical stimulation; electrophoresis with Nivalin; occupational therapy, ergotherapy (for children over the age of 5) [5, 9].

In order to register the level of recovery at the beginning and at the end of the monitored period, measurements and tests are conducted as per the injury type and children’s age. The children between 0–5 are centimeter-measured (measurements of a forearm, armpit and length of upper limb). With children over 2 various arm grips are tested (grabs – spherical, cylindrical, fist grip, hook grip) due to their lower type injury [4], and children with upper type of injury and over the age of 5 are tested through manual muscle tests of mm. rhomboidei (major et minor), m. supraspinatus, m. infraspinatus, mm. deltoidei, m. biceps brachii.

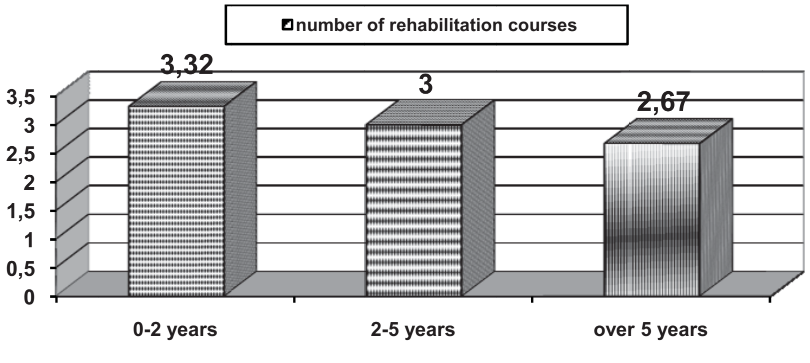

Fig. 2. Average number annually of completed rehabilitation courses by age group

Because of the small number of children in the age groups as per type of injury, the results received have no statistical reliability, and this provoked us to do an inquiry (with open and standard replies) among the parents, having in mind the age of their children, so we could register the efficacy of the treatment.

Parents of 2-year old children replied to the following questions:

1. Do you understand the importance of systematic and active rehabilitation treatment, including treatment in home conditions?
2. Are you familiar enough with the supporting kinesiotherapeutic procedures for your child outside the medical centres?
3. Do you see improvement in movements of the injured limb?
4. Do you consider that your child falls behind in their physical development?
5. Do you have financial means to provide your child with treatment?

The questionnaire for parents with older children (aged over 2) contains additional questions:

6. Does your child go to a kindergarten?
7. Does your child cope with everyday life activities – toilet and personal hygiene, eating, dressing up and putting shoes on, other domestic activities?
8. According to your observations, does the child use the injured limb in everyday life activities or avoid using it?

Results and analysis

The centimeter measures of children up to the age of 2, at the beginning of the monitored period showed on average 0,5 cm hypotrophy of the injured limb (difference between the good limb, forearm and armpit) and preserved length of the limb. These results remain unchanged at the end of the one-year period. For the children up to the age of 5 the hypotrophy at the beginning of the study reached on average 1,6 cm, the limb was shortened by 2,1 cm. For children over 5 the average results are respectively 2,3 cm hypotrophy and 3,4 cm shortened limb. At the end of the monitored period changes are difficult to be registered, which is explained by the common growth at this age. The grip test is made in age group 3 and 4 (4 children with total injury), and the average values are 3(+) for the first rehabilitation course for the year and 4(-) for the end of the monitored period. The results from the muscle tests of 6 children with upper type of injury, aged over 5, showed he improved condition of the tested muscles, but also a tendency for contractures in shoulder and elbow joints.

When analyzing the results of fig.2, we can summarize that for the 2-year old children the completed rehabilitation courses are extremely insufficient – on average 3,32 (27,1%), against the need and ability to complete the courses each month. The children from the second age group completed on average 3 rehabilitation courses, which is 75% from the 4 courses during the year they are entitled to. The fact is explained by the replies to the first question *„Do you understand the importance of systematic and active rehabilitation treatment, including treatment in home conditions?”*, to which 27% of the parents show hesitation in assessing the situation properly. This is also connected with the replies to the next question *„Are you familiar enough with the supporting kinesiotherapeutic procedures for your child outside the medical centres?”,* where the same parents gave similar replies. The fact calls for targeted work with the parents, because they are the adults supposed to accompany the children to the rehabilitation ward and be responsible for their health. Of crucial importance is training of the parents as to how to work daily with the child between the rehabilitation courses, to apply possible kynesiotherapeutic techniques and healing procedures, and with older children – sports activities or functional occupational therapy.

The children from the 3rd age group completed the optimum number of rehabilitation courses, but they were not sufficient enough for a better functional recovery.

The question *„Do you see improvement in movements of the injured limb?”* received positive replies from all parents, especially in relation to smaller children with the upper type (neuropraxia). Re-innervation processes are observed after the age of 5-6, which confirms the need for systematic rehabilitation healing simultaneously with the growth [1].

The question *„Does your child go to a kindergarten?”* received mainly positive replies from the parents, but they state the fact that the kindergarten staff is not qualified to stimulate and exercise the injured limb during the daily activities.

The replies to the question *„Do you consider that your child falls behind in their physical development?”* are in all directions, though corresponding to the injury type and age of the child. The motor deficit has no consequences for the mental development, and the parents do not observe any delayed development. Parents of older children and those having children with the upper type of injury do not point out the substantial delay in physical development, but in cases of total injury and lower type of injury the lack of grip seriously impede the use of the upper limb in occupational and school activities, and this is reflected on the general physical development of the child.

As for the questions relevant to *everyday life activities,* the parents of older children also give various replies depending on the type of injury. In families where the child is being observed during the play time, remarks are made for the position of the limb and its use in all possible activities, etc., improved skills for self-service are found. Parents, who are not able to spend more time with their children and belittle the problem, point out that there are more difficulties in including the paretic limb in everyday activities.

The rehabilitation process is slow and extended. It depends on the parents’ responsibility and ability to accompany their children to treatment procedures, especially during the first months after birth. Some parents do not wish or cannot apprehend the crucial character of the problem and this inevitably affects the result. The parents must be convinced that major part in the complex treatment of birth trauma of the brachial plexus is the systematic rehabilitation. As per data from medical literature, about 25% of children with the upper type and neuropraxia, undergoing systematic physiotherapeutic and rehabilitation treatment, recover functionally [1]. Often the results are barely seen or unsatisfactory, especially in relation to hard total injuries (in cases of axonotmesis or neurotmesis), but this is not a reason to discontinue the rehabilitation. 2/3 from the parents replied to the question *„Do you have financial means to provide your child with treatment?”* stating that they face serious financial difficulties in conducting the monthly rehabilitation treatment of smaller children, and for grown up children – difficulties in accompanying by the adult (sick-leave permission or paid leave). All parents point out the unsatisfactory work of the specialized state institutions expected to support the healing process of their children.

Conclusion

In order to achieve good result from rehabilitation of children, suffering from the birth trauma of the brachial plexus, early diagnostics and timely initiation of treatment, regular conduct of rehabilitation courses and making clear the severity of the problem to the parents, as well as their role in the treatment are of crucial importance.

The purpose of the complex physiotherapeutic and rehabilitation programme for children with birth trauma of the brachial plexus is to improve their self-service skills and to support the performance of various occupational and domestic activities as children grow up. Improvement of various hand grips, work with tools and utensils, inclusion of amusing and functional occupational therapy stimulate the performance of everyday life activities, promote the children’s independence, future professional orientation and realization.

Good results come hard and slow, but they significantly raise the options for better quality of life and professional realization of children with birth trauma of the brachial plexus.

References:

1. Gacheva Y. Diagnosis and rehabilitation of children with birth trauma of the brachial plexus. Sofia: Medicine and Physical culture, 1982, 49-50; 67-69; 219-242 [In Bulgarian].

2. Gacheva Y., Boykinova I., Sarafova N. Physical Therapy and Rehabilitation Disease in Childhood. Sofia: Medicine and Physical culture, 1987, 195-205 [In Bulgarian].

3. Georgiev I., Bojinov S. Neurological diseases. Sofia: Medicine and Physical culture, 1982, 89-104; 164-166 [In Bulgarian].

4. Karaneshev G., Miltcheva D. Diagnostics and research in Physiotherapy. Sofia: Higher School of Physical Culture, 1984, 67-72 [In Bulgarian].

5. Karaneshev G., Miltcheva D., Jonkov V., Kojuharova M. Remedial gymnastics in diseases in childhood. Sofia: Higher School of Physical Culture, 1984, 54-65 [In Bulgarian].

6. Health Fund provides – NationalFrame Contract 2015, Clinical Path No. 243 [In Bulgarian].

7. National Statistical Institute., Access mode: http://www.nsi.bg/. Demographic and Social Statistics; Population and demographic processes, 2015 [In Bulgarian].

8. Slanchev P., Bonev L., Bankov St. Guidance on Kinesitherapy. Sofia: Medicine and Physical culture, 1986, 269-270 [In Bulgarian].

9. Petrova M., Borisova M., Chavdarov Iv. New options in early kinesitherapy of children with birth trauma of the brachial plexus. Collection of materials of the Fifth National Conference on Rehabilitation, Pavel Bania, 1990, 24-25 [In Bulgarian].

10. Trombly CA. Occupational Therapy for Physical Dysfunction. Boston – Baltimor – Philadelphia – Hong-Kong – London – New York – Sydney – Tokyo: Williams & Wilkins, 1996, 213-218.

11. Jimmy D. Miller, M.D., Stephanie Pruitt, R.N., And Thomas J. Mcdonald, M.D., Acute Brachial Plexus Neuritis: An Uncommon Cause of Shoulder Pain., Access mode: http://www.aafp.org/afp/2000/1101/p2067.html https://doi.org/10.1046/j.1533-2500.2001.01023-21.x

12. Da b#de priznata specialnost po Hirurgija na r#kata [To be awarded the specialty in Surgery of the Hand]., Access mode: http://surgery.bg/article/priznata-spetzialnost-hirurgiia/14642

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U.D.C. 616.127-005.8-036.11-036.22:313.1](477)

ON MORBIDITY OF THE ACUTE MYOCARDIAL INFARCTION [I.21] AMONG THE POPULATION OF UKRAINE FOR THE PERIOD OF 2000-2013

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Aim of the study. The scientific substantiation of peculiarities of the state of morbidity of acute myocardial infarction (AMI) [I.21] among the population of Ukraine.

Results and discussion. It was established that during the analysed years the morbidity of AMI [I.21] among the citizens of Ukraine has increased by +5387 cases. In 2013 there were 50744 cases of the disease with the prevalence index at 135,7 cases per 100 thousand citizens, which was by +17,9 % higher as compared to the data of 2000 (111,3 cases per 100 thousand citizens).

It is necessary to include the following to the epidemiological peculiarities of the state of morbidity of AMI [I.21] during the analysed years: dominance of the pathology [I.21] among urban residents as compared to residents of villages (by 4,2 times more frequently); augmentation of the AMI [I.21] prevalence coefficient among persons of the working age by +109,8% and among persons of the retirement age by +191,6%; dominance of this pathology [I.21] in 59,9% in favour of males as compared to females; the highest rated index of morbidity level of AMI [I.21] is registered among the population of the Eastern region (155±12,3 cases per 100 thousand citizens) and the lowest (106±3,4 cases per 100 thousand citizens) – among the residents of the Western region of the country; the prevalence in the structure of morbidity of AMI [I.21] - 55,1% G/TMI [I.22.0.1.8]; the low level (15,8%) of coverage by the dispensary observation for those who were sick with AMI [I.21] and G/TMI [I.22.0.1.8] (14,8%).

Keywords: health, patient, morbidity, cardiovascular diseases, myocardial infarction, epidemiological peculiarities, clinical examination, prophylaxis.

Conference participants,
National championship in scientific analytics,
Open European and Asian research analytics championship

http://dx.doi.org/10.18007/gisap:msp.v0i12.1606

Introduction. In the XXI century Ukraine faced a number of challenges in public health sector, which directly and, moreover, negatively affected the state of the demographic situation in the country [1]. Among them was the problem of increasing prevalence of circulatory system diseases [I.00-I.99] as a socially important non-epidemic pathology [2], where the morbidity level – 58 429 cases per 100 thousands of people. It was the main cause of mortality and disability among the population of Ukraine [3 ,4, 5].

Acute myocardial infarction plays an important role [I.21], even though the share of this pathology is low in the structure of morbidity and mortality rates of population due to the circulatory system diseases [I.00-I9.9], but it is particularly important, because it is significantly spread among persons of the working age. In addition, there is the noticeable growth of the mortality level in all age groups, as well as the direct impact on reduction of duration and deterioration of quality of Human life [6].

Aim of the study. The scientific substantiation of pecularities of the state of morbidity of acute myocardial infarction [I.21] among the population of Ukraine.

Materials and methods. Research is done according to the official statistical data of the Ministry of Health of Ukraine concerning the morbidity of population of Ukraine with diseases of the circulatory system [I.00-I9.9] and AMI [I.21]] in particular, for 2000, 2005, 2010 and 2013 [7], with the use of historical, medical and statistical, medical and geographical methods of research, as well as methods of structural and logical analysis and deductive awareness, based on the principles of the systems approach and systems analysis. The epidemiological data was processed and analysed in the automated way using a personal computer with the „Microsoft Office Excel 2010" software.

Results and discussion. Analysis of results of the research clearly showed (graph 1) that the number of diseases due to AMI [I.21] in Ukraine during the analysed years, according to index of absolute growth rate, has increased by +5387 persons, and in 2013 there were 50 744 diseases. According to the index of growth rate there was demonstrated the tendency of rapid in 2005 (by +4313 cases as compared to 2000) and moderate in 2010 (by +334 cases as compared to 2005) and in 2013 (by +740 cases as compared to information of 2010) growth of the AMI level morbidity [I.21] by +117,9%. This occurred against the background of the fact that during the analysed period the number of resident population of Ukraine [8] has decreased according to the index of absolute rate reduction by – 3 417,7 thousand persons, and in 2013 it was 45 245,9 thousand people, whereas the obtained prevalence index of this pathology [I.21] in 2013 was 135,7 cases per 100 thousand of population, which was more (according to the index of growth rate) than in 2000 (111,3 cases per 100 thousand population) by +17,9 %.

It was confirmed that morbidity due to AMI [I.21] during the analysed years affected the rural residents in 19,4±1,1% episodes of the total number of patients with this pathology [I.21] in Ukraine (graph 2), whereas this disease [I.21] among the urban residents was diagnosed 4,2 times more often than among the rural residents, and by the index of structure it was 80,6±1,1%.

It was proved that level of this pathology [I.21] among the rural residents of Ukraine had a tendency to the rapid growth in 2005 (growth rate +28,2% in comparison with the data of 2000); in 2010 – by +17,2% as compared to the index of 2005; in 2013 – by +7,9% as compared to the index of

2010, and in 2013 there were 96,1 cases per 100 thousand rural residents, which (according to the index of growth rate) is more than in 2000 by +162,3%; the index of prevalence was 59,2 cases per 100 thousand of rural residents.

It was confirmed that with regard to the urban residents of Ukraine according to the index of growth rate the coefficient of prevalence of morbidity of AMI [I.21] during the studied period had the undulating nature. In 2005 it was characterized by a growing trend – by +2,8% in comparison with the index of 2000, while in 2010 as compared to the coefficient of 2005 there is the declining trend seen – to the level of 97,3%; in 2013 the index of prevalence of morbidity of this pathology [I.21], according to the growth rate, was aimed at increasing by +122,5% in comparison with the same index of 2010.

Thus, for the analysed years, the AMI morbidity level index [I.21] among urban residents of Ukraine in 2013, according to the index of growth rate, has increased by +110,6% and was 153,3 cases per 100 thousand of urban residents, as compared to the coefficient of 2000 (138,5 episodes per 100 thousand of urban residents).

It was determined that according to the index of structure of this disease [I.21] (graph 3) during 2000-2013 it was recorded by 2,18 times more often among persons of the retirement age (68,6±0,7%), whereas among the population of the working age the AMI morbidity [I.21] was recorded in 31,4± 0,7%.

It was defined that the AMI coefficient prevalence [I.21] among persons of the working age for the analyzed period, in accordance with the index of growth rate, has increased by +109,8% in 2013 in comparison with the same index of 2000; it was 56 cases per 100 thousand population of the working age.

It was clarified that the characterized index among persons of the working age, in accordance with the coefficient of growth rate, was +113,5% higher in 2005 (57,9 cases per 100 thousand of persons of the working age) as compared to the index of 2000, but in 2010 there was the declining trend – by 3,02% in comparison with 2010 (56,2 cases per 100 thousand persons of the working age), and in 2013 – by – 0,35 % (56,0 cases per 100 thousand persons of the working age).

It was shown that in relation to persons of the retirement age the rapid growth of the index of morbidity level due to AMI [I.21] was marked in 2013 – up to +191,5% (517,1 cases per 100 thousand persons of the retirement age) as compared to the same coefficient in 2000 (in 2005 the growth rate was +10,1%) – 297,2 cases per 100 thousand residents of the retirement age; in 2010 – by +61,9% (481,2 incidents per 100 thousand persons of the retirement age); in 2013 – by +7,5% in comparison with the previously analysed indexes.

The results of gender characteristics have revealed the dominance of this disease [I.21] in 2013 (59,8%) in males (index of prevalence – 177,2 cases per 100 thousand men), while among women AMI [I.21] was diagnosed in 40,2% persons, where the morbidity level was 101,7 cases per 100 thousand of females.

Considering that situation when the AMI [I.21] in the state of human health has a great chance to become a threat for life of the patient (especially its clinical form - great focal/transmural myocardial infarction (G/TMI) [I.22.0.1.8], characterized by the spread of necrosis on the entire thickness of the heart muscle from endocardium to epicardium, causing the severe complications, and showing high probability of lethal outcome for the patient), the analysis of the diagnosed G/TMI [I.22.0.1.8] among patients with the AMI [I.21], and certain groups of patients, was performed.

It was established (graph 4) that among all patients with the AMI [I.21] the transmural MI [I.22.0.1.8] in 2013 was diagnosed clinically in 55,1% with the prevalence of this pathology in 74,7 cases per 100 thousand persons in Ukraine.

Among men with the AMI [I.21] in the analysed year in 57,2% of cases the advantage transmural MI was registered [I.22.0.1.8] with the index of frequency at 101,5 cases per 100 thousand of males, while among the female patients due to AMI [I.21] in 51,8% cases the necrosis spread on the entire thickness of the heart muscle from endocardium to epicardium with the prevalence index of transmural myocardial infarction [I.22.0.1.8] at 52,8 cases per 100 thousand females.

It was proved that among the urban residents with the AMI [I.21] the studied coefficient of G/TMI [I.22.0.1.8] in 2013 was 55,9% with the prevalence index at 85,8 cases per 100 thousand of urban population, while among the category of patients [I.22.0.1.8] of rural settlements the considered index was 51,7% (49,7 cases per 100 thousand of rural population) of the total number of this cohort of patients with AMI [I.21].

Furthermore, the analysis of the specific weight of proof of a number of transmural myocardial infarctions [I.22.0.1.8] in 2013 among the total number of patients with the AMI [I.21] confirmed that among the cohort of persons of the retirement age with the pathology of AMI [I.21] the considered index was 55,6% (173,3 cases per 100 thousand population at the retirement age), whereas among patients [I.21] of the working age the analyzed coefficient was 53,8% with the prevalence index of G/TMI [I.22.0.1.8] at 30,1 cases per 100 thousand of the working-age persons.

Territorial peculiarities at the levels of the AMI morbidity [I.21] among the population of regions of Ukraine in 2013 were found out (cartogram 1). It was established that the first rating place in the spread of the AMI morbidity [I.21] had the Eastern region with the index of 155±12,3 cases per 100 thousand citizens. Among the females the analyzed index was 202,1±14,3 cases; among men – 125,3±11,4 cases per 100 thousand citizens of the corresponding sex (table 1).

The second palce in this context was occupied by the population of regions territorially united in the Central region with the coefficient of prevalence of this pathology [I.21] at 146,6±9,2 cases per 100 thousand citizens (197,6±10,4 cases among women and 115,3± 8,8 cases among men per 100 thousand population of the corresponding sex). The third place by the level of index of prevalence of AMI diseases [I.21] had the Southern region of Ukraine: 132±10,7 cases per 100 thousand citizens, where the studied index among females was 178,1±12,9 cases, and among males – 102,6±10,1 cases per 100 thousand citizens of the corresponding sex. Among the residents of regions of the North the AMI morbidity level [I.21] was 113,3±9,2 cases per 100 thousand citizens, which corresponded to the fourth rating place in Ukraine with the value of the prevalence index of this disease [I.21] among females at 156,9±10,7 cases per 100 thousand women and among men – 85,6± 9,4 cases per 100 thousand males. The Western region of the country took the last, the fifth rating position as to the level of AMI diseases [I.21] – 106±3,4 cases per 100 thousand citizens (the index of prevalence among females was 153,6±4,6 cases and among males – 74,6±3,4 cases per 100 thousand persons of the corresponding sex).

Taking into account the significant number of patients with the diagnosed AMI [I.21] (50 744 patients) with the prevalence index of this pathology [I.21] among the population of Ukraine in 2013 at 135,7 cases per 100 thousand persons, we attempted to analyze the coverage of this category of patients [I.21] using the dynamic medical supervision.

It was established, that the index of coverage of dispensary medical observation in relation to patients who had been sick with AMI [I.21] in 2013 was – 15,8%, whereas in relation to patients, who had been sick with G/TMI [I.22.0.1.8] this coefficient was even lower – 14,7%. The situation was no better (and in some cases even worse) with the analyzed indexes of coverage of dynamic medical supervision of patients with the AMI [I.21], including patients after G/TMI [I.22.0.1.8] by sex, age and the place of residence; the data of graph 5 confirmed that.

Consideration of results of the dynamic medical supervision over the analyzed diseases [I.21] and [I.22.0.1.8] proved that the obtained results did not meet the requirements of the decree of the Ministry of Health of Ukraine of 27.08.2010 No. 728 “On dispensarization of population”. In this decree it was mentioned that planning of measures on organization of clinical examination is to be held by the district doctors or general practitioners (family medicine) at a place of residence (to prevent the re-development of the disease and its complication thus ensuring normal vital activity and returning of work capacity), as well as carrying out the healthcare measures (that would positively impact the reduction of the morbidity level, disability and mortality of population caused by diseases of the blood circulation system [I.00-I.99]), and increasing the active lifespan of citizens [9].

Furthermore, it is expedient to refer to content of the Unified clinical protocol of emergency, primary, secondary (specialized) and tertiary (highly specialized) medical aid and medical rehabilitation due to acute coronary syndrome with segment elevation of ST [10], where nothing is mentioned about the clinical observations of this category of patients at the after-hospital stage [I.21].

Conclusions.

1) It was established, that for the analyzed years the AMI [I.21] among the population in Ukraine has increased by +5387 cases, and in 2013 it was 50744 cases of disease with the prevalence index at 135,7 cases per 100 thousand citizens, which was +17,9% higher according to the growth rate index in comparison with 2000 (111,3 cases per 100 thousand citizens).

2) The epidemiological peculiarities of the AMI morbidity [I.21] must include: the dominance of this pathology [I.21] among urban residents – by 4,2 times more often than among rural residents; growth of the prevalence coefficient of AMI [I.21] for the analyzed years among persons of the working age by +109,8% and among persons of the retirement age the rapid growth rate by +191,6%; dominance of this pathology [I.21] in 59,9% in men as compared to women; according to the rating the highest index of the AMI morbidity level [I.21] is among the population of the Eastern region (155±12,3 cases per 100 thousand citizens), and the lowest coefficient of prevalence (106±3,4 cases per 100 thousand citizens) is in the Western region of the country; the prevalence in the structure of the AMI morbidity [I.21] G/TMI [I.22.0.1.8] is in 55,1%; low levels of coverage of the dispensary medical observation of patients who had been sick with the AMI [I.21] is 15,8%, and G/TMI [I.22.0.1.8] – 14,8%.

3) The obtained results confirm that the AMI morbidity and its clinical form – G/TMI [I.22.0.1.8] among the population of Ukraine is a complicated medical and social problem, which requires a real method of solving it with the use of the mechanism of implementation of prophylactic technologies “High risk strategy” in activities of district doctors of the general medicine / family physicians, as well as effective implementation of principles of dispensary medical monitoring over the categories of patients who have been sick with AMI [I.21].

References:

1. Koval’chuk A.Yu. Harakteristika social'no-demografichnoï situaciï ta social'no znachushhih zahvorjuvan' v Ukraïni. Ukraïns'kij medichnij chasopis 2014 [Characteristics of socio-demographic situation and socially significant diseases in Ukraine. Ukrainian medical journal 2014]; 1; 99; I/II. Ukrainian., Access mode: http://www.umj.com.ua/article/71500/xarakteristika-socialno-demografichnoi-situacii-ta-socialno-znachushhix-zaxvoryuvan-v-ukraini.

2. Horbas` I.M. Epidemiologichna situacija shhodo sercevo-sudinnih zahvorjuvan' v Ukraïni: 30-richne monitoruvannja. Prakt. angiologija, 2010 [The epidemiological situation concerning the cardiovascular diseases in Ukraine: 30 years of monitoring. Practical angiology, 2010]; 9–10(38): 15–19. Ukrainian.

3. Ipatov A.V., Korobkin Yu.I., Drozdova I.V., Khanyukova I.Ya., Sydorova M.H. Hvorobi sistemi krovoobigu: providni tendenciï dinamiki invalidnosti. Ukraïns'kij kardiologichnij zhurnal [Diseases of the blood circulatory system: the major disability dynamics trends. Ukrainian Journal of Cardiology 2012]; 1: 36-41. Ukrainian.

4. Kovalenko V.M.. Suchasni prioriteti i rezul'tati rozvitku kardiologiï v Ukraïni. Ukrayins'kyi kardiolohichnyi zhurnal: materialy XIII Natsional'noho konhresu kardiolohiv Ukrayiny, 26–28 veresnya 2012 r. [Modern priorities and results of development of cardiology in Ukraine. Ukrainian Journal of Cardiology: Proceedings of the XIII National Congress of Cardiologists of Ukraine, September 26-28, 2012]., 2012; 2: 3-8. Ukrainian.

5. Handzyuk V.A. Dinamika zahvorjuvanosti ta poshirenosti

sercevo-sudinnih hvorob sered naselennja Ukraïni na suchasnomu etapi: nacional'nij ta regional'nij aspekti [Dynamics of morbidity and prevalence of cardiovascular diseases among the citizens of Ukraine at the present stage: national and regional aspects]., Visnyk sotsial'noyi hihiyeny ta orhanizatsiyi okhorony zdorov"ya Ukrayiny 2014 [Journal of Social Hygiene and Healthcare Organization in Ukraine]; 2: 74-78. Ukrainian.

6. Kulayets' N.M. Pervinna profilaktika sercevoï nedostatnosti – odin iz prioritetiv suchasnoï kardiologiï [Primary prophylaxis of heart failure – one of the priorities of modern cardiology]., Visnyk problem biolohiyi i medytsyny 2014 [Journal of Medical and Biological Issues, 2014]; 3; 1; 110: 185-189. Ukrainian.

7. Pokazniki zdorov'ja naselennja ta vikoristannja resursiv ohoroni zdorov'ja v Ukraïni za 2000-2013 roki., Centr medichnoï statistiki MOZ Ukraïni [Indices of health of the population and use of healthcare resources in Ukraine during 2000-2013., Medical statistics centre of the Ministry of Health of Ukraine]. – Kiev., 2001-2014.

8. Derzhavna sluzhba statistiki Ukraïni. Demografichna situacija. Chisel'nist' naselennja (shhomisjachna informacija) [State Statistics Service of Ukraine. Demographic situation. The population size (monthly information)]., 2013., Access mode: http://ukrstat.org/uk/operativ/operativ2013/ds/kn/kn_u/kn1213_u.html.

9. Nakaz MOZ vid 27.08.2010 roku za № 728 "Porjadok dispanserizaciï naselennja" [Decree of the MoH of 27/08/2010 No. 728 "Procedure of clinical examination of population"]., Access mode: http://www.moz.gov.ua/ua/portal/dn_20100827_728.html.

10. "Nakaz MOZ Ukraïni vid 02.07.2014 roku za № 455 "Unifikovanij klinichnij protokol ekstrenoï, pervinnoï, vtorinnoï (specializovanoï) ta tretinnoï (visokospecializovanoï) medichnoï dopomogi ta medichnoï reabilitaciï pri gostromu koronarnomu sindromi z elevacієju segmenta ST" [Order of the MoH of Ukraine of 02/07/2014 No. 455 "The unified clinical protocol of emergency, primary, secondary (specialized) and tertiary (highly specialized) medical aid and medical rehabilitation in acute coronary syndrome with ST segment elevation"]., Access mode: http://pci-ua.org/files/protokol_ami_ukranian/Protokol_Sokolov.pdf.

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SECONDARY LYMPHEDEMA OF LIPS AS A SYMPTOM OF OROFACIAL LESIONS

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The study involved 18 patients with the secondary lymphedema of lips, Melkersson-Rosenthal syndrome, Granulomatous cheilitis of Miescher, Crohn's disease, and chronic odontogenic periapical inflammation. Based on the data of clinical and ultrasound examinations authors have established the similarity of the clinical picture and the course of lymphedema in these diseases. The authors suggest not to consider the secondary lymphedema of lips an independent nosological entity.

Keywords: lips lymphedema, macrocheilitis, Melkersson-Rosenthal syndrome, Granulomatous cheilitis of Miescher, Crohn's disease.

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http://dx.doi.org/10.18007/gisap:msp.v0i12.1607

Lymphedema is a congenital or an acquired disease of the lymphatic system, associated with the abnormality of the outflow of lymph from the lymphatic capillaries and peripheral lymphatic vessels from organs and tissues to the main lymphatic collectors and the thoracic duct, which leads to an increase in the size of the affected organ.

Lymphedema occurs when lymphatic load exceeds the transport capacity of the lymphatic system. The imbalance between the formation of lymph and its outflow occurs in the course of various diseases, including the orofacial pathology. Primary lymphedema occurs more rarely, in idiopathic or acquired vascular malformations, especially in their hypoplasia or aplasia. Secondary Lymphedema usually develops in impairment of lymph transportation due to damage or resection of lymphatic vessels and lymph nodes, infections and radiation [6, 8].

In dental clinics they adhere to the same systematics and consider lymphedema of lips as primary pathology (ICD-10: Q82.0 Hereditary lymphedema. Q18.6 Macrocheilia) and secondary pathology (ICD-10: I89.0 Lymphedema, not elsewhere classified) [14].

The literature describes secondary lymphedema of lips in a number of diseases, one of the leading clinical symptoms of which is macrochilia [4, 7, 9, 12], but there is no information about the features of the clinical picture of swelling of each of these diseases.

The aim of our study was to offer the comparative evaluation of the clinical picture of secondary lymphedema of lips with orofacial lesions.

Materials and methods. Survey of 18 patients aged 51-73 was conducted; among them there were 15 women and 3 men. Patients were sent for consultations to the department with various orofacial pathologies, where the main symptom of disease was macrochilia. Patients underwent clinical, radiological, laboratory and ultrasound examination. Clinical and laboratory tests – according to the generally accepted methods, orthopantomography – on apparatus PDX0771000, ultrasound – on Toshiba «Aplio» of expert class using Doppler ultrasound.

Results and discussion. Analysis of the results of a complete examination of patients allowed determining the Melkersson-Rosenthal syndrome in 5 patients. Among these patients, 2 were directed with the erysipelas face. In 3 patients the syndrome was characterized by the classic symptoms, in 2 – two symptoms. Moreover, one patient formed a triad of symptoms during 25 years. In 2 patients together with the gastroenterologist we diagnosed the «Crohn›s disease». Granulomatous cheilitis of Miescher was diagnosed in 3 patients. The cause of the remaining 8 cases of macrochilia was the local stomatogenic pathology (granulating periodontitis, radicular cyst, periodontal disease with bone pockets, a chronic relapsing labial fissure).

Despite the different genesis of the disease all patients have a common symptom – lips are increasing in size due to their edema. They complained of discomfort in the affected lip, the feeling of heaviness and tightness in it, violation of diction. Pain was absent.

The same type for macrochilia was characteristic for the medical history. As a rule, patients noted cyclic course with sequences of relapse and remission periods. Firstly the edema of the upper or lower lip appeared, which lasted from a few weeks to several months. In remission period the edema did not disappear completely; with each subsequent relapse its strengthening was observed.

During the examination the edema of the upper or lower lip was determined. It was generalized and even or asymmetrical, damaging more than one of the halves of the lips. Edema captured topographically only one or two lips, sometimes spread beyond it. Most often, the skin of the lips had elements of pigmentation due to telangiectasia, slight cyanosis. On the vermillion zone there were signs of trophic disorders – sometimes atrophy and thinning of the skin, peeling, angiectasis (Fig. 1, 2).

Tissues were of tightly-elastic consistency at palpation, painless; after pressing the marks remained. In the lips thickness the small nodules were slightly palpable (small salivary glands).

Ultrasonography has determined the heterogeneity of structure without clear contours, decreased echogenicity, increased vascularization and vasodilatation in lips thickness.

In patients with odontogenic factors as the cause of lymphedema, the signs of apical periodontitis, radicular cysts,

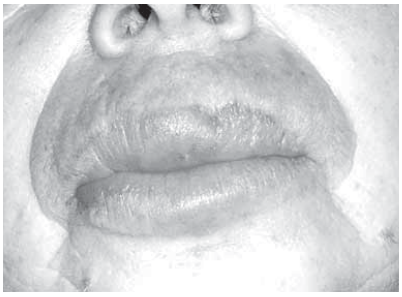

Fig. 1. Patient T., 68 years old. Lymphedema of the upper lip.

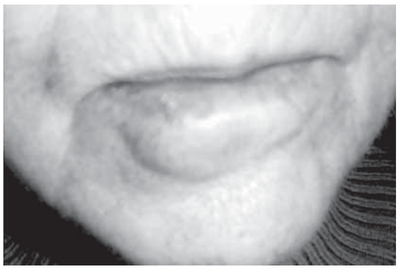

Fig. 2. Patient L., 70 years old. Lymphedema of the lower lip.

deep bone periodontal pockets were determined on orthopantomography (Fig. 3).

Data of laboratory examinations were within the age norm. Thus, clinical and ultrasound picture of lymphedema of lips and its clinical course had common features, despite the different genesis of the disease.

The most recognizable in the clinic the Melkersson-Rosenthal syndrome is a rare disease of unknown ethology. Clinical manifestations are characterized by the typical triad of symptoms: swelling of face and lips, peripheral facial paralysis and fissured tongue. According to the literature data, only 75.4% of patients have this syndrome accompanied by the classical triad, the others have one or two symptoms [3, 12]. This is confirmed by our study. Sometimes the syndrome is accompanied not only by the swelling of lips, but also other parts of the face, particularly by isolated edema of the upper eyelid [2].

Among the diseases, having the edema of lips as their symptom, Granulomatous cheilitis of Miescher can also be noted [5, 7]. There is evidence of a combination of granulomatous cheilitis with vulvitis. Moreover, the results of histological studies indicate their similarity [1]. A similar morphological pattern of lips edema in cases of Granulomatous cheilitis of Miescher and Melkersson-Rosenthal syndrome is noted by other researchers [5, 7].

Some authors separately determine the orofacial granulomatosis [10]. It is also a rare disease that is characterized by persistent or recurrent swelling of the soft tissues of the mouth, ulceration, and the presence of the non-caseating granulomas in the tissues thickness. This term was introduced to integrate a range of different disorders, including the Melkersson-Rosenthal syndrome and granulomatous cheilitis (which is sometimes considered a mono-symptomatic form of the Melkersson-Rosenthal syndrome), and is regarded as synonymous of the previously considered disease [11].

Conclusions. The similarity of the data of anamnesis, clinical and other methods of research of the secondary lymphedema of lips allow us to consider it symptomatic, and not to allocate this pathology as a separate nosological entity.

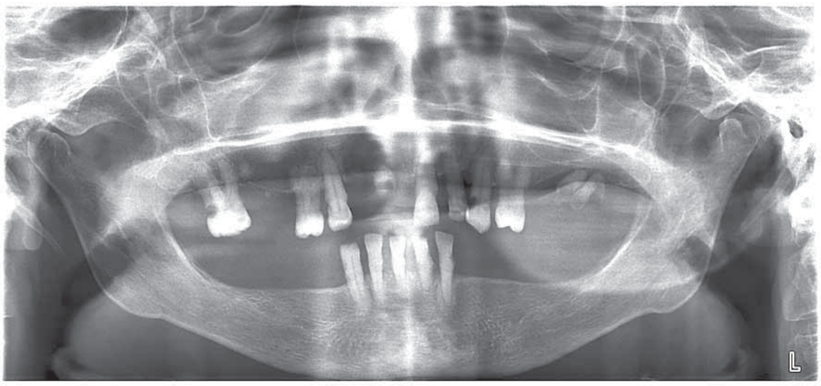

Fig. 3. Patient T., 68 years old. Orthopantomogram.

References:

1. A case of idiopathic granulomatous cheilitis and vulvitis. Sbano P, Rubegni P, Risulo M, De Nisi MC, Fimiani M. Int J Dermatol. 2007; 46(7): 720-721. https://doi.org/10.1111/j.1365-4632.2007.03173.x

2. Application of microcurrents of bioresonance and transdermal delivery of active principles in lymphedema and lipedema of the lower limbs: a pilot study. Elio C., Guaitolini E., Paccasassi S., Rosati N., Cavezzi A. G Ital Dermatol Venereol. 2014; 149(6): 643-647.

3. Brar B.K, Mahajan B.B, Kamra N. Cheilitis granulomatosa (Miescher granulomatous macrocheilitis) with Down syndrome: A rare alliance. Indian J Paediatr Dermatol. 2016; 17: 50-52. https://doi.org/10.4103/2319-7250.172458

4. Case of cheilitis granulomatosa associated with apical periodontitis. Kawakami T, Fukai K., Sowa J., Ishii M., Teramae H., Kanazawa K. J Dermatol. 2008; 35(2): 115-119. https://doi.org/10.1111/j.1346-8138.2008.00426.x

5. Cheilitis granulomatosa associated with Melkersson-Rosenthal syndrome. Gonçalves D.U., de Castro M.M., Galvão C.P., Brandão A.Z., de Castro M.C., Lambertucci J.R. Braz J Otorhinolaryngol. 2007; 73(1): 132-133. https://doi.org/10.1016/s1808-8694(15)31136-8

6. Foldi M., Foldi E. Lymphostatic diseases. In: Strossenruther R.H, Kubic S, editors. Foldi's textbook of lymphology for physicians and lymphedema therapists. 2. Munich, Germany: Urban and Fischer. 2006: 224–240. https://doi.org/10.1177/000331978303400202

7. Granulomatous cheilitis of Miescher: the diagnostic proof for a Melkersson-Rosenthal syndrome. Răchişan AL, Hruşcă A, Gheban D, Căinap S, Pop TL, Băican A, Fodor L, Miu N, Andreica M. Rom J Morphol Embryol. 2012; 53(3 Suppl):851-853.

8. Ji R.C. Lymphatic endothelial cells, lymphedematous lymph-angiogenesis, and molecular control of edema formation. Lymphatic Research and Biology. 2008, 6(3-4): 123-137. https://doi.org/10.1089/lrb.2008.1005

9. Oral Crohn's disease.

Padmavathi B., Sharma S., Astekar M., Rajan Y., Sowmya G. Journal of Oral and Maxillofacial Pathology: JOMFP. 2014; 18 (Suppl 1): 139-S142. https://doi.org/10.4103/0973-029x.141369

10. Orofacial Granulomatosis: Clinical Signs of Different Pathologies. Troiano G., Dioguardi M., Giannatempo G. [et al.]. Med Princ Pract 2015; 24: 117-122. https://doi.org/10.1159/000369810

11. Rana A.P. Orofacial granulomatosis: A case report with review of literature. J Indian Soc Periodontol. 2012;16:469-6474 https://doi.org/10.4103/0972-124x.100934

12. Retrospective analysis of 69 patients with Melkersson-Rosenthal syndrome in mainland China. Tang J.J. [et al.]. International journal of clinical and experimental medicine. 2016; 9(2): 3901-3908.

13. Szuba A., Rockson S.G. Lymphedema: classification, diagnosis and therapy. Vasc Med. 1998; 3(2): 145-156. https://doi.org/10.1191/135886398674160447

14. МКБ-10. Режим доступа: http://mkb-10.com/

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U.D.C. 616-002-089

EFFECTIVENESS OF NON-INVASIVE SURGERY IN PATIENTS WITH THE COLON BLEEDING

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The authors have observed 37 patients with intestinal bleeding from tumours of the large intestine of varying severity.

The effectiveness of endoscopic hemostasis by laser photocoagulation of vessels and the value of this technique in the prevention of recurrent bleedings was assessed.

In 12 patients the bleeding was stopped by applying the hemostatic therapy. In 25 patients an attempt was made to arrest the intestinal bleeding through the colonoscopy with laser photocoagulation of vessels of the tumour using the high-energy argon plasma installation and the neodymium laser with a wavelength of 1.06 microns.

Non-contact laser argon coagulation of bleeding vessels of the tumour was successfully applied in 14 cases.

This treatment strategy is promising because it allows performing the one-stage surgery with minimal risk to the patient.

Keywords: endoscopic hemostasis, laser photocoagulation, neodymium laser, argon laser photocoagulation.

Conference participants,
National championship in scientific analytics

http://dx.doi.org/10.18007/gisap:msp.v0i12.1608

Background. According to the literature, the frequency of bleeding from the colon in the general population is 0.03% annually, and in the age group from 20 to 80 it progressively increases by nearly 200 times. The average age in the group of patients with this pathology is between 62 and 75, and mortality is up to 4-5% [3]. Malignant tumors, diverticulitis, and ischemic colitis are the most common causes of colon bleeding. [3.4]. At present colonoscopy is a necessary method of complex endoscopy used to identify the source of bleeding. It performed after gastroduodenoscopy except for the cases when the source of bleeding is located in the upper gastrointestinal tract. In addition, colonoscopy is performed upon detection of tumors and acute ulcers during the gastroduodenoscopy in order to avoid their presence in the colon [4]. According to most authors, the primary kind of endoscopy, colonoscopy should be made: a) in presence of anamnestic indications of localization of the bleeding source in the colon; b) in the early period after surgery on the colon; and c) if you suspect the presence of a malignant neoplasm of the colon [3]. According to the summarized data, modern diagnostic accuracy of colonoscopy for bleeding from the lower gastrointestinal tract is 72-86% [2]. Nowadays, there are the following methods of hemostasis:

I. Injection hemostasis. It consists of direct introduction of the agent into the bleeding area.

II. Thermocoagulation. The coagulators are brought directly to the bleeding area to cause coagulation and thrombosis. Multipolar coagulation is also used, in which an electric discharge passes via multiple electrodes on the tip of the catheter, as well as argon plasma coagulation, which are approximately equally effective.

III. Mechanic hemostasis. It assumes application of endoclips on the bleeding vessel.

IV. Combined methods of therapeutic endoscopy. At present, there is evidence supporting the use of therapeutic endoscopy, which combines injection hemostasis (sclerotherapy, injection of adrenalin) with thermal or mechanical one, especially in the course of treatment of patients with very severe and active ulcer bleeding.

The relapse rate of bleeding is 15-20%. It usually develops within the first 24 hours after surgery, especially in profuse initial bleeding. When managing the patient with recurrent bleeding and determining indications for surgical treatment, there can be doubts. [4]. Thus, expectant management is justified for some patients with recurrent bleeding in successful therapeutic re-endoscopy, but the next relapse is an absolute indication for surgical treatment. In our work we used thermocoagulation by applying laser photocoagulation of tumor vessels using the high-energy argon plasma installation and neodymium laser with a wavelength of 1.06 microns.

Objective: 1) to clarify the capabilities of fibrocolonoscopy in determining and verifying the source of bleeding intensity in the colon, 2) to evaluate the effectiveness of a technique of endoscopic hemostasis by laser photocoagulation of the blood vessels and 3) to determine the value of this method in prevention of bleeding recurrence.

Materials and methods. The study period covers 2011-2014. All patients were divided by the degree of bleeding severity. In this case, we used the classification of Gostischev V.K., Evseev M.A., 2005.

Determination of the degree of hemorrhage severity is very important for solving the tactics of treatment and determining the nature of transfusion therapy.

We followed up 37 patients who had been admitted with symptoms of intestinal bleeding of various degree of severity and 21 patients with anemia. The age of the patients varied from 40 to 88. The average age of the patients was 64 years old. Elderly patients dominated. As to gender, women prevailed in all age groups – 34 (58.6%), and there were 24 men (41.3%).

As to the degree of bleeding severity the patients were distributed as follows: mild degree – 15 (40.5%) patients, moderate – 14 (37.8%) patients, severe – 8 (21.6%) patients.

Results: The cause of bleeding in all patients was colon tumor. In 12 patients the bleeding was stopped by application of hemostatic therapy. In other cases, we have performed noninvasive surgery. Preparation of patients is important because colonoscopy is difficult in patients with active bleeding, for with poor preparation of the patient it is not always possible to identify a bleeding source. To improve the diagnostic value of this method (sensitivity is 80% for angiodysplasias) careful preparation of the patient is required, compensation of blood volume, adequate anesthesia, as the excessive use of narcotic analgesics leads to peripheral vasodilation. By using cleansing and siphon enemas, we tried to remove the remnants of feces and blood clots. After thorough emptying the distal intestine in 25 patients, we attempted to stop intestinal bleeding by colonoscopy followed by tumor location and tumor vascular laser photocoagulation using a high-energy argon plasma installation and neodymium laser with a wavelength of 1.06 microns. We did not use the contact electrocoagulation of vessels of the destructing tumor because of the high probability of tumor perforation.

Non-contact laser argon coagulation of bleeding vessels of the tumor was successful in 14 cases, which allowed stabilizing the patient's condition for a long time and gave time for thorough examination and preoperative preparation of the patient for performing radical surgery in 2-3 days.

This technique did not lead to control of bleeding in 11 patients, who required urgent surgical intervention with removal of the tumor bleeding substrate.

While making endoscopic hemostasis, we obtained the following complications: persistent bleeding in 10 cases and in one case there was a bowel wall perforation, which required urgent surgery.

In the group of patients with anemia (22) we carried out blood transfusion and infusion therapy followed by diagnostic and therapeutic colonoscopy. In 17 cases we were able to run a double-lumen probe through the obstruction zone under the control of the endoscope, followed by administration of drugs and fluids for washing off and aspiration of feces, thus improving the patient's condition, to solve the phenomena of acute intestinal obstruction temporarily and prepare the patient for radical surgery in 2-5 days.

Endoscopic recanalization of the colon was performed in 12 cases with the use of high-energy laser devices. A tumor was revealed after the colonoscopy. If the tumor occupied most of the intestinal lumen in visualization, laser photocoagulation of the tumor tissue, coagulating the tumor tissue, was performed.

When a small canal was formed after the destruction of the tumor tissue, we tried to pass the probe through the obstruction area in the proximal part of the intestine. If this manipulation was ineffective, then the examination was ended, and this manipulation was repeated in 24 hours. Upon reaching the effect of passing the double-lumen probe above the tumor obstruction, the intestine was washed off using the medicines. A positive effect was achieved in 10 cases.

When performing these manipulations, we have faced the following complications: perforation of the tumor occurred during tumor laser photocoagulation in one case that required urgent laparotomy; ulcer wall perforation occurred in the intestine diverticulum by the double-lumen probe in the process of photodecomposition in the second case, that also required urgent laparotomy with removal of the tumor and damaged parts of the intestine; and in the third case there was a recurrence of bleeding requiring further argon plasma coagulation.

In 10 cases we were able to run the endoscopic stent through the site of bowel obturation by the tumor. Stenting of the bowel at the site of the tumor obstruction along with resolution of obstruction are also provided by mechanical hemostasis.

The stenting procedure is a complex endoscopic technique possible only in cases where there is no complete tumor intestinal obstruction. In cases of complete obstruction when trying to pass a stent, there may be bleeding and perforation of the bowel wall with development of peritonitis.

In case of effective installation of the stent, it is possible to clear the bowels quickly and efficiently and eliminate acute intestinal obstruction, allowing to perform a radical traditional or laparoscopic surgery in 2-5 days after the stent installation.

Besides, installation of the stent and elimination of the threat of full germination of the colon lumen with a tumor, allows preventing intestinal obturation and refusing the surgery in case of tumor metastasis in various organs and manifestations of carcinomatosis.

We managed to pass and install the stent in 10 cases. In one case, there was bleeding in the process of the stent installation, when attempts to install the stent (due to difficult visualization and complete obstruction of the lumen of the colon tumor) had led to bowel perforation and fecal peritonitis, which required urgent laparotomy with resection of the bowel with the tumor.

Thus, endoscopic techniques require a highly skilled endoscopist, specialized skills, as well as advanced endoscopic and laser equipment.

Based on the data given, it should be noted that the use of endoscopic techniques helps stop bleeding in 60% of cases. It also allows obtaining management of acute intestinal obstruction in 72% of cases with tumors of the left half of the colon, allowing to make a high-quality preoperative preparation of patients, to reduce the risk of surgery and in most cases, to perform the laparoscopic surgery. Application of this method in complex techniques to stop bleeding increases the efficacy of therapeutic endoscopy and contributes to stabilization of patients, preoperative preparation, and also reduces the number of complications.

In our opinion this treatment strategy is promising, because it allows performing one-stage surgery with minimal risk to the patient and avoiding 2- or 3-stage operations in most cases.

Conclusions.

1. Endoscopic local hemostasis is an effective method, which allows stopping bleeding in the patients with colorectal cancer in 60-70% of cases.
2. The most effective method of endoscopic bleeding control is a combined method of laser photocoagulation with introduction of fibrin glue, as well as stenting.
3. The endoscopic hemostasis allows stabilizing the patient's condition, to conduct an effective preoperative preparation, to conduct one-step surgery, and to reduce postoperative complications by 2 times.

References:

1. Ovchinnikov V.Yu. Rol' i mesto sovremennykh metodov vizualizatsii v diagnostike i lechenii ostroy kishechnoy neprokhodimosti, vyzvannoy rakom obodochnoy kishki: avtoref. diss. kand. med. nauk [The role and place of modern imaging methods in the diagnostics and treatment of acute intestinal obstruction caused by colorectal cancer: author's abstract of the thesis for the Candidate of Medicine]., V.Yu. Ovchinnikov. – Moskva., 2010. - 23 p.

2. Uryadov S.Ye., Shapkin YU.G., Kapralov S.V., Endoskopicheskiy gemostaz pri tolstokishechnykh krovotecheniyakh., Saratovskiy nauchno-meditsinskiy zhurnal [Endoscopic hemostasis in colonic bleeding., Saratov Medical Scientific Journal]., 2010., No. 3., pp. 719-720

3. Pirlet IA., Slim K., Kwiatkowski F. et al. Emergency preoperative stenting versus surgery for acute left-sided malignant colonic obstruction: a multicenter randomized controlled trial.SurgEndosc 2011; 25; pp. 1814–1821 https://doi.org/10.1007/s00464-010-1471-6

4. Cennamo V., Luigiano C., Coccolini F. et al. Meta-analysis of randomized trials comparing endoscopic stenting and surgical decompression for colorectal cancer obstruction. Int J Colorectal Dis 2013; 28: 855-863 https://doi.org/10.1007/s00384-012-1599-z

Литература:

1. Овчинников В.Ю. Роль и место современных методов визуализации в диагностике и лечении острой кишечной непроходимости, вызванной раком ободочной кишки: автореф. дисс. канд. мед. наук., В.Ю. Овчинников. - М., 2010. - 23 с.

2. Урядов С.Е., Шапкин Ю.Г., Капралов С.В., Эндоскопический гемостаз при толстокишечных кровотечениях., Саратовский научно-медицинский журнал. 2010., № 3., с. 719-720

3. Pirlet IA., Slim K., Kwiatkowski F. et al. Emergency preoperative stenting versus surgery for acute left-sided malignant colonic obstruction: a multicenter randomized controlled trial.SurgEndosc 2011; 25; 1814–1821

4. Cennamo V., Luigiano C., Coccolini F. et al. Meta-analysis of randomized trials comparing endoscopic stenting and surgical decompression for colorectal cancer obstruction. Int J Colorectal Dis 2013; 28: 855-863

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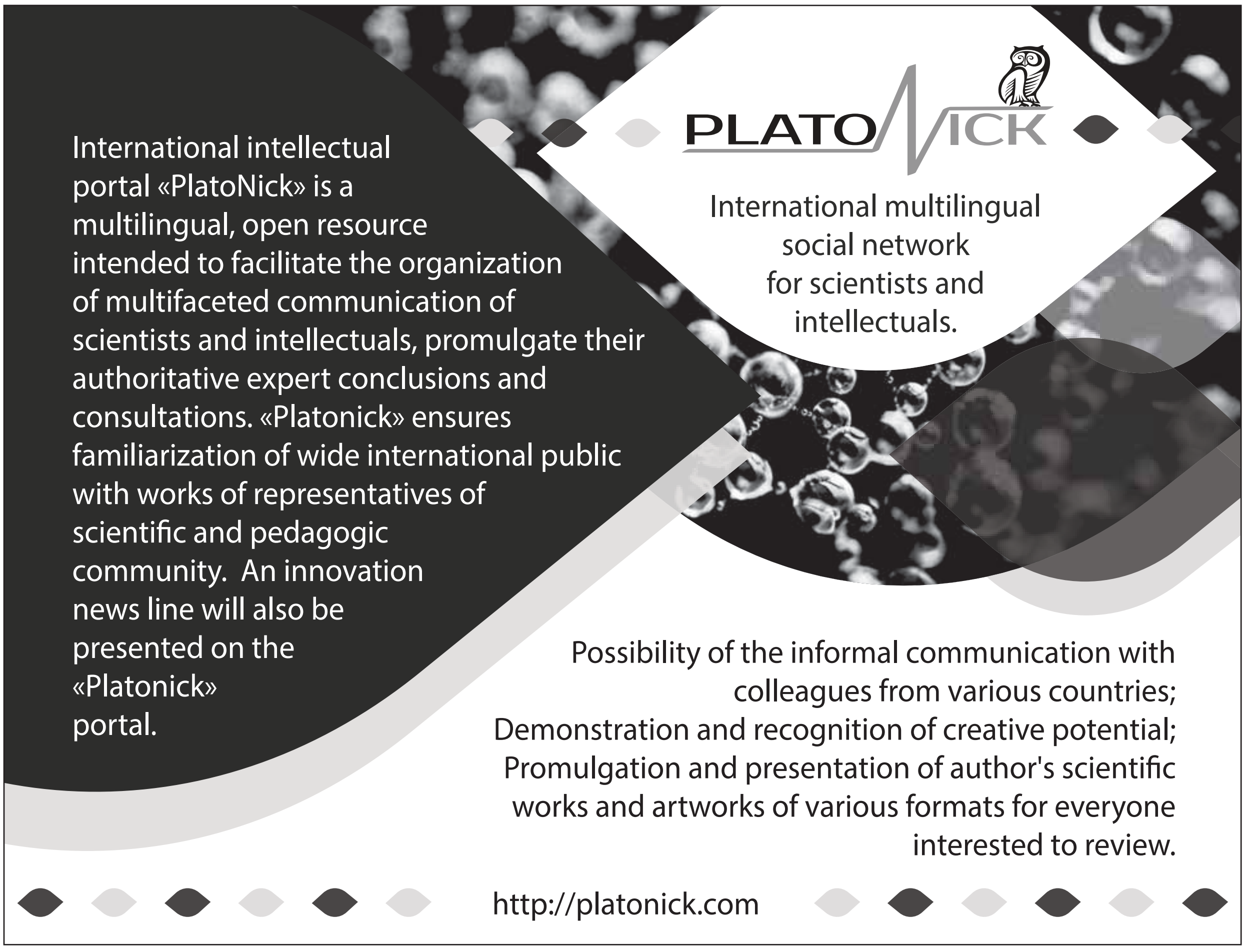

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SELF-PURIFICATION PROCESS IN THE CENTRALIZED AND DECENTRALIZED WATER SOURCES IN THE RURAL SETTLEMENTS

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This research is aimed at describing the dynamics of nitrification activity in the centralized and decentralized water supply sources in the rural taxons of the Dnepropetrovsk region during 2008-2014. The authors have shown the dynamics of nitrates activity in water from the decentralized water supply sources in 6 rural taxons of the Dnepropetrovsk region for 2008-2014.

Keywords: nitrates activity, drinking water, self-purification, decentralized sources, rural taxons.

Conference participants,
National championship in scientific analytics,
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http://dx.doi.org/10.18007/gisap:msp.v0i12.1609

Introduction

Officially, the Dnepropetrovsk region has the following water resources: superficial – 0.24 thousands m^3 / year per 1 person (average index in Ukraine is 1.02 000 m^3 / year per 1 person); underground – 0.12 thousands m^3 / year per 1 person (in Ukraine the standard indicator is 0.44 thousands m^3 / year per 1 person). In general, the centralized water-supply system covers about 20 cities, 270 rural settlements [1, 2]. In the Dnepropetrovsk region about 19% of rural settlements were covered with the centralized water supply system with numerous infringements during exploitation. Majority of rural settlements: 626 settlements used drinking water from drilled wells, well known as an unprotected superficial aquiferous horizon. Peasants living in 267 rural settlements, i.e. 61 thousand people were provided with bottled water, transferred from large cities using the special transport [3]. The Ukrainian government provided about 66.6% population with the centralized disposal systems (and about 52% peasants in the rural settlements). As a result, the large cities should be covered with the sewage system; according to the hygienic standards – from 50 to 98.4%, in the provinces – from 5 to 47.6% [4]. Thus, this research is aimed at describing the dynamics of nitrification activity in the centralized and decentralized water supply sources in the rural taxons of the Dnipropetrovsk region during 2008-2014.

Materials and Methods

In our research the water quality indicators were determined using the sanitary-toxicological methods: concentrations of nitrogen ammonia, nitrites and nitrates (general number of laboratory tests carried out in the centralized sources – 38 260; in the decentralized water sources – 24 586). Nitrification activity in both types of drinking water sources for 2008-2014 was investigated according to the requirements of the National Standard GOST 7525:2014 [5] and the State Sanitary Norms and Rules 2.2.4-171-10 [6].

Results and Discussion

Indicators of nitrification activity in the drinking water from the centralized water sources of the 1 taxon (nitrogen ammonia, nitrites and nitrates) did not exceed the maximum admissible concentration (MAC), except for the indicator of 2012. Over-normal concentration of nitrites (15.45 ± 0.04) mg/dm^3 – 30.9 MAC and oxidation (5.57 ± 0.08) mg/dm^3 – 1.11 MAC was revealed in 2012. The level of nitrites in the drinking water was significantly increased by 1.7 times in terms of dynamics: from (0.018 ± 0.005) to (0.031 ± 0.014) mg/dm^3. In this case, an average annual indicator for nitrites was on the level of 2.22 ± 0.02 mg/dm^3, i.e. 4.44 MAC.

As for the surface sources, the tendency to the decreasing level of nitrates and ammonia nitrogen during the 6-year period was shown, indicating the adverse dynamics of self-cleaning of drinking water in the 1 rural taxon. On the one hand, the ammonia nitrogen level has decreased: from (0.31 ± 0.08) mg/dm^3 in 2008 to (0.22 ± 0.06) mg/dm^3 in 2013; thereafter it was growing to the initial level: (0.31 ± 0.05) mg/dm^3 in 2014 ($p = 0.243$). On the other hand, at the same period of observation nitrates content has decreased significantly – by 2.6 times: from (2.80 ± 0.80) to (1.07 ± 0.39) mg/dm^3 ($p < 0.001$). Indicators of nitrification activity (ammonia nitrogen, nitrites and nitrates) demonstrate the self-purification processes typical for the centralized sources in the 2 taxon, because the dynamics between 2008 and 2014 has shown the decreasing level of ammonia nitrogen and increasing level of nitrates concentrations. This clearly indicates the nitrification activity occurring in the drinking water sources. So, the nitrogen of ammonia in the drinking water has significantly decreased by 1.2 times – from (0.19 ± 0.01) to (0.16 ± 0.03) mg/dm^3 ($p < 0.001$). While the nitrates in dynamics have significantly increased by 2.3 times: from (1.07 ± 0.47) to (2.50 ± 0.25) mg/dm^3 ($p < 0.001$).

In the surface drinking water sources of the 3 taxon a higher than normal average annual concentration of ammonia nitrogen was registered: 1.06 MAC (in 2009), 1.52 MAC (in 2011). Thus, a significant decrease of nitrogen ammonia against the background

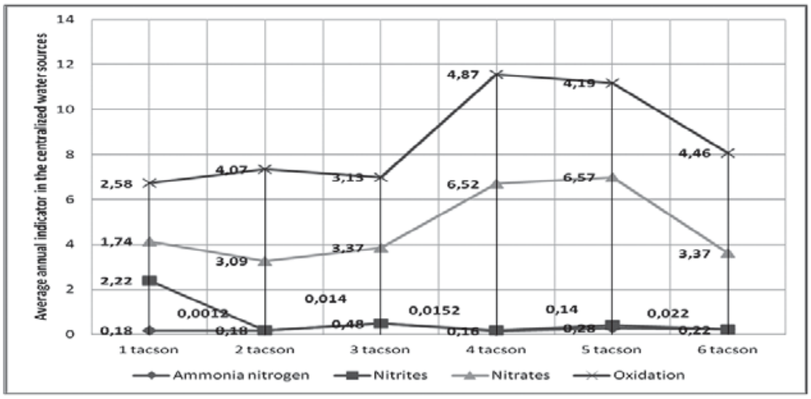

Fig. 1 a. Dynamics of nitrification activity and oxidation in the centralized water supply sources in the rural tacsons of Dnepropetrovsk region (by the average annual indicators).

of decreasing nitrates content was determined. Therefore, the content of ammonia nitrogen has reduced from (0.34±0.03) to (0.17±0.03) mg/dm^3 against the background of decreasing of nitrates by 1.3 times: from (3.18±0.27) to (2.44±0.41) mg/dm^3 ($p = 0.229$; $p<0.001$).

In the centralized water sources of the 4 taxon we have observed incompleteness of a nitrification process, because during 7 years the ammonia nitrogen and nitrates levels have increased, but the nitrites have decreased. The highest content of ammonia nitrogen was registered in 2011: 0.22±0.01 mg/dm^3 ($p<0.001$). Unfavourable self-purification processes were registered in surface sources of the 5 taxon, because in terms of dynamics the levels of ammonia nitrogen, nitrites and nitrates were significantly increased. So, ammonia nitrogen level was significantly increased by 1.12 times: from (0.17±0.01) to (0.19±0.05) mg/dm^3 ($p = 0.229$; $p<0.001$) between 2008 and 2014. Unfavourable nitrification activity occurred in the centralized water supply sources of the 6 taxon. Thus, in the surface water sources significantly decreased ammonia nitrogen, nitrites, nitrates and oxidation were determined. Decreasing of the ammonia nitrogen level by 2.9 times has been registered between 2008 and 2014: 0.12±0.01 mg/dm^3 ($p<0.001$), nitrates have decreased by 1.6 times: 2.71±0.53 mg/dm^3 ($p<0.001$), nitrites have decreased by 5.6 times: 0.005±0.002 mg/dm^3 ($p<0.001$). The given trend demonstrates the unfavourable self-cleaning activity of water in the majority of rural taxons, because the levels of ammonia nitrogen, nitrites, nitrates, and oxidation have decreased in terms of dynamics (see Fig. 1a).

The same trend of poor self-purification process in the decentralized water sources was observed in the 1 taxon. Data of our research demonstrated the significant growth of the level of ammonia nitrogen and nitrites, and decrease of nitrates, according to the GOST 7525:2014 requirements for underground water sources. In this taxon the level of ammonia nitrogen has increased by 1.4 times: from (0.23±0.02) to (0.32±0.07) mg/dm^3 ($p=0.243$; $p<0.001$). The given trend was typical for nitrites in the underground water sources in some years: in 2008 (1.65 MAC); in 2009 (1.25 MAC); in 2012 (3.0 MAC); in 2013 (1.5 MAC); in 2014 (3.05 MAC). Level of an average annual indicator of nitrites has increased (42.5 MAC). Therefore, nitrates have decreased by 1.75 times in the underground sources: from (8.08±0.89) to (4.60±0.02) mg/dm^3 ($p < 0.05$). However, in the 1 taxon from time to time the level of nitrates increased: in 2008 (1.6 MAC); in 2010 (2.7 MAC); in 2011 (1.7 MAC); an average annual indicator level is 1.2 MAC.

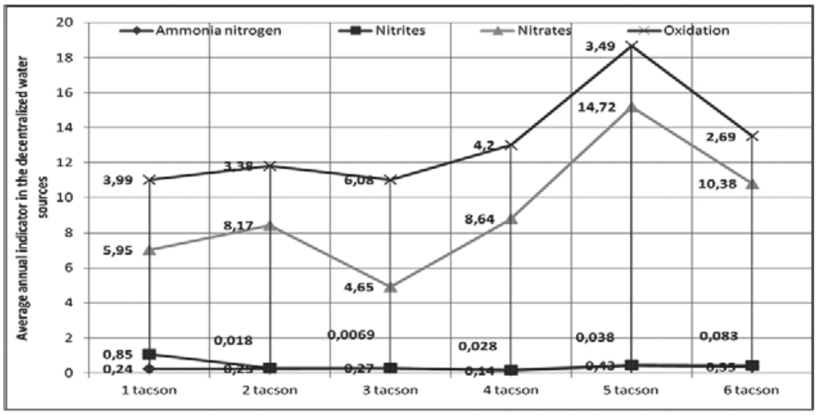

Fig. 1 b. Dynamics of nitrification activity and oxidation in the decentralized water supply sources in the rural tacsons of Dnepropetrovsk region (by the average annual indicators).

So, in the 2 taxon the decentralized water supply sources have shown unfavourable self-purification processes. The results of analysis suggest the trend to decreasing ammonia nitrogen, nitrites, nitrates between 2008 and 2014. However, the increase of ammonia nitrogen has been shown: (1.6 – 2.0) MAC between 2008 and 2010; nitrites (2.0 – 3.0) MAC between 2008 and 2013; nitrates (3.5 – 4.0) MAC between 2008 and 2011. Consequently, the ammonia nitrogen level has significantly decreased by 2.0 times: from (0.24±0.16) to (0.14±0.07) mg/dm^3 ($p<0.001$). Similar trend was revealed in this taxon for nitrates, which increased by 4.1 times in terms of dynamics: from (9.47±0.54) to (2.29±0.006) mg/dm^3 ($p<0.001$). Thus, the highest content of nitrates was revealed in 2010: 13.31±3.95 mg/dm^3, the lowest content (< 5.0 mg/dm^3) – in 2012.

Results of monitoring of the drinking water quality in the 3 taxon demonstrate the unfavourable nitrification activity in the decentralized sources by the ammonia nitrogen and nitrites. Average annual indicator of ammonia nitrogen in the 3 taxon was on the level: 0.27±0.05 mg/dm^3, nitrites – 0.0069±0.0019 mg/dm^3, nitrates – 4.65±0.02 mg/dm^3. In some years of monitoring of the drinking water the trend to growth of nitrates was registered: in 2008 – 6.96±0.33 mg/dm^3, i.e. (1.4 MAC); in 2013 – 7.54±0.14 mg/dm^3, i.e. (1.5 MAC). Sometimes, nitrates decreased periodically: in 2008 (6.96±0.33) mg/dm^3 and in 2014 (0.56±0.04) mg/dm^3 ($p<0.001$).

Drinking water sources in the 4 taxon has been characterized by unfavourable self-purification and incompleteness of nitrification activity for a 7-year period. Thus, in 2008 there were the following levels: ammonia nitrogen (0.15±0.01) mg/dm^3; nitrites (0.039±0.014) mg/dm^3; nitrates (13.62±2.77) mg/dm^3 ($p<0.001$). In 2014 all these indicators have decreased in terms of dynamics: ammonia nitrogen (0.12±0.01) mg/dm^3; nitrites (0.018±0.007) mg/dm^3; nitrates (11.48±4.09) mg/dm^3 ($p<0.001$), i.e. (1.25 MAC), (2.2 MAC), (1.2 MAC). The significant trend in growth of all these compounds in the drinking water has been revealed: in 2008 – nitrites (2.0 MAC), nitrates (3.0 MAC); in 2009 – nitrites (5.5 MAC), nitrates (1.2 MAC); in 2011 – nitrates (3.4 MAC); in 2012 – nitrates (1.5 MAC); in 2014 – nitrates (2.3 MAC). Average annual indicators have also increased: nitrites (1.4 MAC), nitrates (2.0 MAC), oxidation (6.0 MAC). On the other hand, level of ammonia nitrogen was permissible. In 2014 indicators of nitrification activity were the following: (0.30±0.12) mg/dm^3 – ammonia nitrogen; (0.0016±0.0004) mg/dm^3 – nitrites; (11.57±4.03) mg/dm^3 – nitrates ($p<0.001$). Thereafter, these parameters have increased: nitrites (2.0 MAC) in 2008; (4.1 – 4.6 MAC) between 2010 and 2011; (1.05 MAC) in 2012; (2.0 MAC) – by an average annual indicator.

Results of our study of the decentralized water sources in the 6 taxon demonstrate good nitrification activity by low level of ammonia nitrogen and nitrites, and high level of nitrates. So, in 2008, the ammonia nitrogen has significantly increased and reached the level of 0.58±0.02 mg/dm^3, nitrites – 0.10±0.009 mg/dm^3; nitrates – 6.09±0.25 mg/dm^3 ($p<0.001$). In 2014, the ammonia nitrogen has decreased by 2.4 times and was on the level of 0.24±0.05 mg/dm^3; nitrites – by 3.5 times (0.029±0.008) mg/dm^3; nitrates level has increased by 4.3 times (26.48±2.49) mg/dm^3. Ammonia nitrogen had never increase MAC, except for 2013: 0.37±0.08 mg/dm^3, i.e. (4.0 MAC). On the other hand, nitrates exceeding MAC in the decentralized water supply sources should cause methemoglobinemia among peasants of the 6 taxon. Thus, between 2008 and 2009, nitrates content was on the level of 1.2 MAC; in 2010 – 1.08 MAC; between 2011 and 2012 – 1.3-1.6 MAC; between 2013 and 2014 – 3.0-5.3 MAC; average annual indicator was 2.08 MAC. In 2014 the highest content of nitrates in the drinking water was registered: (26.48±2.49) mg/dm^3 (see Fig. 1 b).

Conclusions

In the decentralized water supply sources all taxons, except for the 6 taxon, showed unfavourable self-purification processes and incompleteness of nitrification activity. Therefore the average annual indicators in the water samples, taken in 1-5 taxons, increased in dynamics by the nitrogen ammonia: from (0.24±0.05) to (0.43±0.20) mg/dm^3, i.e. by 2.0 times, as compared to the content of nitrates: (5.95±0.06) to (14.72±5.57) mg/dm^3, which increased by 2.5 times ($p < 0.001$). It was proved that water from the decentralized sources in the 1-5 taxons of the Dnepropetrovsk region did not correspond to the GOST 7525:2014 being intoxicated by high concentration of nitrites and nitrates between 2008 and 2014. All taxons of the Dnepropetrovsk region, except for the 2 taxon, did not correspond to certain indicators: 1 taxon – nitrites (30.9 MAC) in 2012; 3 taxon – nitrogen ammonia (1.06 – 1.52) MAC in 2009, 2011, (1.42 MAC) in 2012, 2013, (1.36 MAC) in 2014; 4 taxon – oxidation (1.33 – 1.15) MAC in 2008, 2014; 5 taxon – nitrogen ammonia (1.02 MAC) in 2011, nitrites (1.6 MAC) in 2014.

References:

1. Borsunova, E.A., Kusmin, S.V., Acramov, R.L. 2007. «Estimation of drinking water quality to the population health». Hygiene and sanitation. 3: 32-34. (in Russian)

2. Audinov, H.V., Priadko, L.I., Scvortsova, S.A. 2010. «Role of water factor in the non – infectious pathology among the Rostov region population». In Proceedings of the 10th Conference in Rostov HMU, 33-34. (in Russian)

3. Pribytkov, Yu.N. 1972. «Status of phosphoric-calcium exchange at the Shevchenko city inhabitants, using drinking water with low level of salt». Hygiene and sanitation. 1: 103-105. (in Ukrainian)

4. Stavitskyi, E.A, Rudko, H.I., Yakovleva, E.O. 2011. «Strategy of using the underground drinking water resources for water supply». 1: 347. (in Ukrainian)

5. Prokopov, V.O. 2009. «Problems of the centralized economic - drinking water supply in Ukraine, ways of profilactic». Technopolis. 10: 12-17.

6. State Sanitary Norms and Rules 2.2.4-171-10 «Hygienic requirements to drinking water, intended for human consumption».

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EPIDEMIOLOGICAL AND CLINICAL PECULIARITIES OF HIV INFECTION, ASSOCIATED WITH MYCOBACTERIUM LEPRAE IN PATIENTS (MEDICAL, SOCIAL AND HYGIENIC ASPECTS)

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Relevance. Many scientific papers demonstrate that HIV infection can change the clinical progression of leprosy, but very little epidemiological and clinical data on this co-infection can be found in the available sources. The review paper shows the geographical distribution and demographic characteristics of 92 HIV patients co-infected with Mycobacterium leprae, which were provided with the qualified assistance in the Brazilian information centre of leprosy. The current paper includes the multidimensional analysis with the help of which the clinical peculiarities of progression of leprosy type 1 reactions were determined. The analysis of current data concerning the visits to the information centre has shown that the number of co-infected persons has been steadily growing over the last years. Prevalence rate of leprosy was the highest among man at the age of 32.3. The use of antiretroviral therapy was the only factor associated with the leprosy type 1 reaction. The majority of patients lived in the central part of the region or in the North of Rio de Janeiro, in Brazil. Persons living in regions characterised by high density of poor population were most often registered among the patients infected with HIV and leprosy.

Keywords: immunodeficiency syndrome, erythematous plaques, type 1 lepra reaction.

Conference participant,
National championship in scientific analytics,
Open European and Asian research analytics championship

ЭПИДЕМИОЛОГИЧЕСКИЕ И КЛИНИЧЕСКИЕ ОСОБЕННОСТИ ТЕЧЕНИЯ ВИЧ – ИНФЕКЦИИ, АССОЦИИРОВАННОЙ С МИКОБАКТЕРИЯМИ ЛЕПРЫ У ПАЦИЕНТОВ (МЕДИКО–СОЦИАЛЬНЫЕ И ГИГИЕНИЧЕСКИЕ АСПЕКТЫ)

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Актуальность. Во многих статьях показано, что ВИЧ-инфекция может изменять клиническое течение лепры, но очень мало эпидемиологических и клинических данных об этой ко-инфекции встречается в доступной литературе. В обзорной статье описаны географическое распространение и демографические характеристики у 92 ВИЧ/ ко-инфицированных пациентов микобактериями лепры, которым была оказана квалифицированная помощь в Бразильском справочно-информационном центре проказы. В статье описан многомерный анализ, с помощью которого устанавливали клинические особенности течения лепрозных реакций 1 типа. Как показал анализ последних данных обращаемости в справочно-информационный центр, количество больных с ко–инфекцией неуклонно растет на протяжении последних лет. Распространённость лепры была чаще среди мужчин в возрасте 32,3 года. Использование антиретровирусной терапии было единственным фактором, связанным с 1 типом реакции лепры. Большинство пациентов проживали в центральной части региона или в северной части Рио-де-Жанейро, в Бразилии. Среди пациентов с ВИЧ и проказой, скорее всего, встречались представители, проживающие в регионах, характеризующихся высокой плотностью обедневшего населения.

Ключевые слова: синдром иммунодефицита, эритематозные бляшки, 1 тип лепрозных реакций.

Участник конференции,
Национального первенства по научной аналитике,
Открытого Европейско-Азиатского первенства по научной аналитике

http://dx.doi.org/10.18007/gisap:msp.v0i12.1610

Введение. В ряде исследований доказана причинно – следственная связь между социально-экономическими факторами и распространением инфекционных заболеваний. Такое детальное исследование факторов может объяснить географические и социально-демографические особенности распространения лепры и возможной кластеризации различных инфекционных заболеваний на территории одного географического района или среди пострадавшего населения. Таким образом, исследование лепры включает в себя изучение различных факторов, таких как различные тропические болезни, ВИЧ/СПИД в условиях нищеты и выраженной социально-экономической и географической неоднородности. С начала эпидемии СПИДа в начале восьмидесятых, роль ко-инфекции в сочетании с тропическими болезнями, туберкулезом, лейшманиозом и малярией были изучены в Бразилии [1, 2].

Как недавно показали исследования в журнале: «Lancet” при надлежащем уровне борьбы с инфекционными заболеваниями как ключевым фактором профилактики эпидемий в мировом масштабе, возможно, управлять различными коинфекциями, и необходимо обеспечить оптимальный уход для тех, кто уже заражён ВИЧ/СПИДом [3]. Несмотря на доказательства того, что ВИЧ-инфекция может изменять естественное течение лепры [4], существует мало эпидемиологических данных о ко-инфекции ВИЧ/микобактериях лепры, опубликованных в литературе [5].

Проказа встречается главным образом в странах тропических и субтропических регионов мира. Согласно докладам ВООЗ, 105 стран сообщили о 219 075 новых случаях возникновения ко- инфекции в течение 2011 года [6], хотя наблюдается тенденция к сокращению общей распространенности и впервые выявленным случаям заболевания в последние годы, проказа остается актуальной проблемой общественного здравоохранения в Бразилии. В 2011 году показатель распространенности заболевания составил 1,54 случая на 10 000 жителей и 33 955 новых случаев проказы были обнаружены по всей стране [7].

К тому же, ВИЧ-инфекция остаётся одной из наиболее серьезных проблем здравоохранения вследствие своего пандемического характера и высокой заболеваемости и смертности в районах, где эффективная терапии остаётся недостижимой. По оценкам ВООЗ, 2,5 миллиона людей были ВИЧ-инфицированными в 2011 году и 34 миллиона человек были обнаружены с симптомами ВИЧ – инфекции в конце 2011 года в Бразилии, эпидемия СПИДа стабилизировалась в течение последних 10 лет. В 2011 году, показатель заболеваемости составил

20,2 случая на 100 000 жителей, 38 776 новых случаев заболевания СПИДом зарегистрированы по всей стране [8].

На сегодняшний день, нет достоверной оценки числа СПИД/лепро ко-инфицированных больных, по данным официальных публикаций. Однако, анализ данных документальных источников и архивов подтверждает вспышки обоих заболеваний в самых бедных регионах Бразилии, а также в расположенных к югу от Сахары в Африке и Юго-Восточной Азии очагов этой ко – инфекции. В последнее десятилетие, внимание научного сообщества обращено на вспышки проказы и ВИЧ ко-инфекции 1 типа лепрозной реакции после инициации комбинированной антиретровирусной терапии [4] больных лепрой, имеющих ко-инфекцию. Поражённые ВИЧ поддаются более высокому риску развития 1 типа лепрозных реакций, также общеизвестно, что лепрозная реакция является результатом иммунологического сдвига у пациента на уровне воспаления и/или клеточно - опосредованного иммунитета, который, в свою очередь, может привести к ускоренному повреждению нерва и к серьёзным физическим недостаткам.

Для оценки клинических и эпидемиологических моделей ВИЧ-инфекции/микобактерий лепры у ко-инфицированных пациентов в Бразилии, данные о пациентах с проказой получены путём выкопировки из справочно-информационного центра, расположенного в городе Рио-де-Жанейро, обобщены и проанализированы. Для оценки географического распределения ко-инфицированных пациентов были использованы амбулаторные карты с адресами местных жителей. Кроме того, оценивались сопутствующие факторы, связанные с 1 типом реакции лепры, а также социально-демографические и клинические данные из медицинских карт.

Результаты исследования. Город Рио-де-Жанейро является основным и наиболее важным муниципалитетом в Бразилии, с населением около 6 320 446 человек. Несмотря на то, что второй по богатству город в стране (первый был Сан-Паулу), Рио-де-Жанейро пострадал из – за укоренившегося социально-экономического неравенства [6], значительная часть его населения все ещё живет в тяжелых жизненных условиях [7]. Город из 160 кварталов исторически делится на четыре региона: южный, северный, западный и центральный. Согласно последней переписи 2010 года, в Бразилии, Рио-де-Жанейро население составляло 15 989 929 человек, подавляющее большинство из которых (96,7%) проживали в городских районах, особенно в более крупных районах столицы Рио-де-Жанейро. Рио-де-Жанейро подразделяется на 5 мезо-регионов, а именно Южный, Северный, Северо-Западный и Центральный. Справочно – информационный центр проказы – это центр передового опыта по диагностике лепры, лечению и уходу, а также отслеживанию контактных лиц. Под эгидой Министерства здравоохранения Бразилии, оценка ВИЧ/лепро ко-инфицированных пациентов, началась проводиться с 1989 года.

Характеристики пациентов на момент постановки диагноза. С января 1989 г. по декабрь 2011 г., 92 больных лепрой с ВИЧ положительной серологией были переданы в центр клиники лепры. Большинство из этих пациентов (83/92; 90%) имели диагноз ВИЧ, установленный до диагноза проказы и у 9 (10%) пациентов диагноз ВИЧ был поставлен во время обнаружения проказы. Из 92 пациентов, пятьдесят два (57%) были мужского пола, средний возраст на момент постановки диагноза составил 32,3 года, возраст всех пациентов колебался в пределах (18-72) лет. Семейное положение и образование были доступны для 86 из 92 пациентов, включенных в базу данных. Подавляющее большинство из них (70/86; 81%) не состояли в браке (одинокие и разведенные). Большинство (66/86; 77%) имели от 1 до 8 лет формального школьного образования, в то время как 21% (18/86) посещали школу более 8 лет и 2% (2/86) никогда не посещали школу.

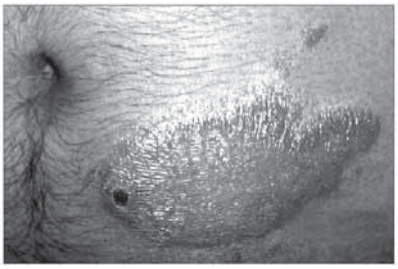

Рис. 1. Эритематозные бляшки в случае пограничной туберкулоидной лепры 1 типа.

Хотя подавляющее большинство пациентов были классифицированы как носители paucibacillary (71/92; 77%), потому что они имели бациллоскопический индекс равный нулю, почти половина (41/92; 45%) пациентов имели негативный тест на лепру (<5 мм). Из 92 пациентов, включенных в исследование, 33 (36%) пациента находились на стационарном лечении проказы, а в момент установления диагноза 32 (97%) пациента имели 1 тип и один пациент 2 тип лепрозных реакций. Ридли и Джоплинг предложили критерии, которые используются для классификации 59 пациентов, у которых не была обнаружена положительная реакция на лепру, следующим образом: у двух (3%) пациентов классифицирован туберкулоидный тип реакции; у 33 (56%) – пограничный туберкулоидный тип; у четырёх (7%) – пограничное воспаление; у пяти (8%) – границы лепроматозной реакции; у двух (3%) пациентов лепроматозный тип реакции; у 11 (19%) пациентов – неопределенный тип, а у двух (3%) – нейронные признаки клинической формы лепры.

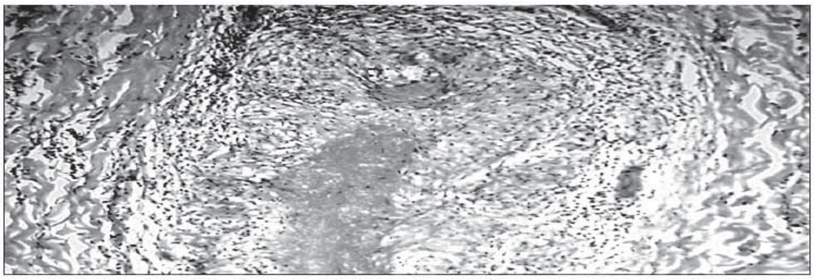

Рис. 2. Казеозные гранулёмы вдоль нервно-сосудистого пучка с инфильтрацией нервов в случае 1 типа лепры (x400).

Обсуждение. Результаты обзорной статьи ни в коем случае не представляют все типичные случаи ко-инфекции ВИЧ/ микобактерий лепры среди жителей Рио-де-Жанейро, так как исследование зарубежных авторов было основано на вероятности случайной выборки из единого центра лечения проказы в городе Рио-де-Жанейро. В качестве справочно-информационного центра, в клинике получают лечение преимущественно пациенты с тяжёлыми проявлениями болезни, такими как 1 тип реакции лепры. Все-таки объём недостающих данных, связанных с особенностями течения ВИЧ-инфекции, получен при дальнейшем детальном анализе пациентов, находящихся на учёте в базе данных этого центра.

До 2013 года, 92 ко-инфицированных пациентов в данной обзорной статье составляют наибольшую когорту пациентов ВИЧ/микобактерий лепры, по данным результатов исследований в зарубежной литературе. Зарубежные авторы убеждены, что большинство пациентов с ко-инфекцией ВИЧ/микобактерий лепры в штате Рио-де-Жанейро были взяты из базы данных центра, и выявлены по результатам обращаемости в центр лепры. В данном обзоре литературы показано, что растущее число ко-инфицированных пациентов с лепрой были выявлены в течение последних 15 лет при обращении в поликлинику. За аналогичный период наблюдения, количество случаев выявления проказы и СПИДа снизилось в Рио-де-Жанейро. Одно из возможных объяснений этого заключается в том, что недавний рост вспышек лепры с 1997 года, и возможность доступа антивирусной терапии в центре лепры стали доступными для всех больных СПИДом в Бразилии.

Некоторые авторы предположили, что начало терапии связано с клинической картиной проказы. Таким образом, появление клинических признаков лепры у лиц с ВИЧ – инфекцией не считается проявлением иммунной супрессии, так как являются маркерами иммунной перестройки. Хотя ожидалось, что ВИЧ-инфекция приведет к увеличению частоты мультибациллярных форм лепры, настоящий обзор показывает, что ВИЧ/микобактерии лепры у ко-инфицированных пациентов может быть одним из проявлений клинических форм лепры. На самом деле, результаты обращаемости пациентов показали более высокий процент пациентов с бациллярной формой проказы. Бацилла Paucibacillary лепры характеризуется сильным клеточным иммунным ответом при поражениях кожи, содержащихся ввиде хорошо организованной гранулемы. Существует гипотеза, что основные антигенные стимулы, связанные с постепенным восстановлением иммунной компетентности после начала терапии лепры, может ассоциироваться с появлением гранулемы и последующим появлением туберкулоидный реакции кожи и нервных поражений.

Реакции 1 типа лепры являются вторичными после усиления клеточного иммунитета и гиперчувствительности замедленного типа микобактерий лепры. Известно, что специфическое антивирусное лечение лепры связано с резкой вирусной нагрузкой у ВИЧ – инфицированных, тогда как уменьшение и последующее увеличение CD4 Т-клеток, является ключевым маркером частичного восстановления иммунной функции. Чтобы полностью выяснить, является ли высокая частота 1 типа лепрозной реакции ответом на диагноз, о чём свидетельствуют исследования большинства зарубежных авторов, или является следствием иммунологического восстановления, спровоцированная применением лечения, необходимы дальнейшие исследования в этой научной сфере. Тем не менее, начало лечения, как сообщается, будет связано с активацией субклинического течения инфекции лепры и обострением ранее существовавших поражений проказой. Как например, использование лечения было единственным независимым фактором, связанным с наличием реакции 1 типа лепры на момент постановки диагноза. Социально-демографические характеристики ко-инфицированных пациентов при их первом посещении специализированного центра, представленные здесь, были похожи на те, что наблюдаются среди случаев, выявленных в Бразилии по всей стране. Национальная база данных, связанных с заболеваниями, показывает более высокую концентрацию пациентов-мужчин между 30 и 59 годами, как было обнаружено в настоящем обзорном исследовании. Из пациентов в возрасте до 15 лет были госпитализированы в клинику меньшинство, хотя эту категорию составляли 3,4% от всех новых случаев проказы в штате Рио-де-Жанейро в 2010 году. Это объясняется низкой заболеваемостью СПИДом у детей в Бразилии (8,1/100 000 случаев в 2010 году).

References:

1. Morgado MG, Barcellos C, Pina MF, et al. Human immunodeficiency virus/acquired immunodeficiency syndrome and tropical diseases: a Brazilian perspective. Mem Inst Oswaldo Cruz 2000;95 (Suppl 1): 145-51. https://doi.org/10.1590/s0074-02762000000700024
2. Orsini M, Canela JR, Disch J, et al. High frequency of asymptomatic Leishmania spp. infection among HIV-infected patients living in endemic areas for visceral leishmaniasis in Brazil. Trans R Soc Trop Med Hyg 2012; 106: 283-8. https://doi.org/10.1016/j.trstmh.2012.01.008
3. Co-infection: new battlegrounds in HIV/AIDS. Lancet Infect Dis 2013;13:559 https://doi.org/10.1016/s1473-3099(13)70171-3
4. Pavie J, De Castro N, Molina JM, et al. Severe peripheral neuropathy following HAART initiation in an HIV-infected patient with leprosy. J Int Assoc Physicians AIDS Care (Chic) 2010; 9: 232-5. https://doi.org/10.1177/1545109710373829
5. Sarno EN, Illarramendi X, Nery JA, et al. HIV-M. leprae interaction: can HAART modify the course of leprosy? Public Health Rep 2008; 123: 206-12. https://doi.org/10.1177/003335490812300213
6. Talhari C, Mira MT, Massone C, et al. Leprosy and HIV coinfection: a clinical, pathological, immunological, and therapeutic study of a cohort from a Brazilian referral center for infectious diseases. J Infect Dis 2010; 202: 345-54. https://doi.org/10.1086/653839
7. Couppie P, Domergue V, Clyti

E, et al. Increased incidence of leprosy following HAART initiation: a manifestation of the immune reconstitution disease. AIDS2009; 23: 1599-600. https://doi.org/10.1097/qad.0b013e32832bb5b7

8. WHO. Geneva: World Health Organization; 2012. Weekly Epidemiological Record: Global leprosy situation., Access mode: http://www.who.int/wer/2012/wer8734.pdf [accessed 13 August 2013]. https://doi.org/10.1002/9780471462422.eoct992

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PSYCHO-DIAGNOSTIC EXAMINATION OF WOMEN WITH THE BREAST CANCER IN THE PROCESS OF COMPLEX REHABILITATION

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Mental and physical health of patients suffering from the breast cancer is largely dependent on the autogenous picture of the disease and intensity of the psychological and professional stress, as well as existence of adequate conditions determining the satisfaction with life and motivation of those suffering.

Psycho diagnostic examination of women with the breast cancer in the process of comprehensive rehabilitation is determined by application of various methods of psycho-diagnostics. The principle of comprehensive rehabilitation of cancer patients is considered to be the most effective, as the pathological process is characterized by lesions of many body systems (Grushin T. I.). Rehabilitation after treatment of the breast cancer is one of the components of complex treatment of cancer patients.

Keywords: patients with breast cancer, comprehensive rehabilitation, somatogenic mechanism of the cancer effect on the psyche, psychogenic mechanisms, depression, psychotherapy of cancer.

Conference participants

ПСИХОДИАГНОСТИЧЕСКОЕ ИССЛЕДОВАНИЕ ЖЕНЩИН С РАКОМ МОЛОЧНОЙ ЖЕЛЕЗЫ В ПРОЦЕССЕ КОМПЛЕКСНОЙ РЕАБИЛИТАЦИИ

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Состояние психического и физического здоровья больных, страдающих от рака молочной железы в значительной степени зависит от аутогенной картины заболевания и интенсивности психо-профессионального напряжения, от обеспечения надлежащих условий, определяющих удовлетворенность жизнью и мотивации тех, кто страдает.

Психодиагностическая оценка женщин, страдающих раком молочной железы, в процессе комплексной реабилитации, определяется путем применения различных методов психодиагностики. Принцип комплексной реабилитации онкологических больных признается наиболее эффективным, поскольку патологический процесс характеризуется поражением многих систем организма (Грушина Т. И.). Реабилитация после лечения по поводу рака молочной железы является одной из составляющих комплексного лечения онкологических больных.

Ключевые слова: пациенты с раком молочной железы, комплексная реабилитация, соматогенный механизм влияния онкологического заболевания на психику, психогенные механизмы, депрессия, психотерапия онкозаболеваний.

Участники конференции

http://dx.doi.org/10.18007/gisap:msp.v0i12.1611

Комлексное исследование женщин, страдающих раком молочной железы (РМЖ) включает в себе: соматическое (физиологическое) и психологическое исследование. Для определения соматического заболеваемости женщин, страдающих от РМЖ мы ранее использовали такие методы, как: анкетирование, диалог, клиническое обследование, анализ медицинской документации, клинико-функциональные шкалы и др. Оценка соматических уровней заболеваемости был выполнен с субъективными и объективными трудностями. В исследовании были включены пациенты, которые живут в разных регионах Молдовы и их медицинское обследование, зарегистрирована в Национальном регистре онкологических заболеваний. У онкологических больных отмечаются также психические расстройства, на формирование которых оказывают значительное влияние факт установления диагноза «рак» и необходимость проведения специального лечения (Семке В.Я., Балацкая JI.H., 2007) [5]. Ряд ученных отмечают выраженную социальную дезадаптацию больных после оперативного лечения РМЖ (Андреева Е.Н., 2002; Москвитина С.А., 2012). В литературе не представлено полноценной картины психических и психосоматических изменений личности, эмоциональной и волевой сфер личности женщин с РМЖ в период реабилитации. Реабилитация после лечения РМЖ включает в себя целый комплекс мероприятий, который наиболее эффективен при всестороннем воздействии. Этот процесс представляет собой систему медицинских, профессиональных, психологических, правовых, социальных и иных мероприятий государства и общества в целом, направленных на создание условий и оптимизацию процессов сохранения или восстановления здоровья, трудоспособности, личностного и социального статуса больных и инвалидов в целях наиболее раннего и максимально эффективного возвращения их в обычные условия жизни вместе и наравне со здоровыми членами общества. Важность реабилитации после лечения по поводу рака молочной железы имеет первоочередное значение, как для самого пациента, так и для лечащего доктора.

Ряд ученых: Stolbach L.L., Brandt U.C., 1988; Royak-Schaler R., 1992; Марилова Т.Ю.; Johnson J.B. et.al., 1996, расматривая различные проблемы реабилитации больных РМЖ выявили важность исследования психологических и психофизиологических процессов в клинике данных заболеваний [1,3,4,9].

Это болезнь сопровождается чрезмерным эмоциональным напряжением, приводящим к различного рода психологическим и нервно-психическим расстройствам. Нарушается социально-психологическая адаптация личности и, как следствие, отмечается частая невротизация больных РМЖ.

Рак молочной железы является важной психосоциальной и медицинской проблемой и ее клинический и психосоциальный фон недостаточно исследован. В диагностике РМЖ у больной развиваются состояние стресса и происходят различные психофизиологические и социальные процессы, что во многом определяет качество жизни этих пациенток, страдающих от понижения уровня мотивации и личностного сопротивления в сложном и комплексном лечении. В центральной нервной системе, а впоследствии в психическом состоянии женщин, страдающих от РМЖ, наблюдаются изменения эмоционального, когнитивного и поведенческого уровня, включающие отношение больных к заболеванию и развития психосоматических нарушений. Эти реакции возникают у пациентов с РМЖ, потому что они были подвергнуты посттравматическому стрессу, естественному развитию онкологической патологии, которая имеет многофакторную природу. С одной стороны, это стресс, вызванный болезнью, биологическими факторами, а с другой стороны – стрессом, вызванным будущим прогнозом, изменением качеством жизни после радикального лечения. Рак вызывает психотравматические изменения, переживания связанные с личной жизнью, с семьей, смыслом жизни, женственности, сексуальности и другим вопросами. Поэтому для правильной оценки ВКБ и оказания квалифицированной помощи больным необходимо исследовать и учитывать такие определяющие факторы, как: преморбидные биологические и личностные факторы; характер заболевания и его возможные последствия; социально-психологичекий фон и влияние окружения; медицинские и клинические факторы. Почти у 28% больных РМЖ, в период реабилитации, наблюдается снижение или потеря мотивации, смысла жизни и женственности, а в этих условиях возникают различные психофизиологические заболевания, а также психологические изменения эмоционального состояния, поведения в социуме, переосмысливание ценностей жизни, включая психосоциальную адаптацию. Ученые аргументировали развитие Психоонкологии, науки исследующей не только психофизиологические изменения, но и психосоматические нарушения этих больных. В Мадриде *2008 г. – состоялся X Международный конгресс по Психоонкологии, в рамках которого было проведено 47 сессий по актуальным проблемам психоонкологии [7]. Одним из направлений данной науки – исследование «онкологического» стресса, психофизиологических, психосоциальных факторов, нейровегетативных симптомов, появляющиеся у пациентов с РМЖ в течение посттравматического процесса реабилитации к существующей реальности, что больная будет жить с диагнозом РМЖ. Некоторые авторы свидетельствуют, что пациенты в результате стресса имеют поливалентную симптоматику – состояние нежелательных воспоминаний, состояние избегания и неуверенности в подобных ситуациях, в гиперактивности организма, эмоций, включая некоторые психопатологические симптомы. Также есть авторы, которые выявили факторы, вызывающие эту симптоматику: опасность для жизни, боязнь за завтрашний день, беспомощность, безнадежность, сопутствующей патологии – в 52% случаев. Некоторые исследователи описывают характерную триаду для этих больных – высокий уровень ненависти, страха и тревоги, а также параноидальные симптомы. Они появляются в результате специфической травмы физической и психической, немощной операции, рисков рецидива и метастазирования, отрицаний факта болезни, подозрений и страхом по поводу близких, их негативная оценка. Др. исследователи, подчеркивает высокий уровень соматизации, появления навязчивых идей, депрессий и проявления психотизма. Некоторые авторы подчеркивают, что в 12% случаев эти симптомы у пациентов с РМЖ в период комплексной реабилитации не развиваются. Описывая личностные особенности больных РМЖ при поступлении, можно отметить такие черты, как: депрессивность, тревожность, чрезмерная чувствительность, эмоциональная лабильность, напряженность, раздражительность, неуверенность, подавленность.

Принимая во внимание результаты разных поливалентных исследований, их неоднородности, отсутствие исследования по расстройствам сна у больных с РМЖ, мы провели всестороннее исследование пациентов с РМЖ клинической группы III. Расстройства сна встречается почти у 60% людей, особенно в состоянии депрессии и эйфории. У пациентов с опухолями этот показатель достигает 75-80%. Лечение расстройств сна является разносторонним: от медикаментозного лечения до изощренных методов.

Нарушения сна – характерное явление, как последствие стрессовых влияний посттравматических факторов у тех кто страдает, имея эпизодический или периодический характер. У большинство пациентов (321/386; 83,16±1,06%) наблюдались расстройства сна, преимущественно с трудным засыпанием (29,17±2,3%), частые пробуждения (25,23±2,3%) и усталость от утреннего пробуждения (28,36±2,4%), $p<0,05$. Только 65 больных (16,83±3,2%) отметили отсутствие нарушений сна, которые отличаются значительно по сравнению с данными взрослого населения, которые по оценкам примерно в 50%, имеют различные расстройства сна. Высокий уровень нарушений сна у исследуемых пациентов с РМЖ, подвержен влиянию некоторыми аспектами повседневной жизни, а также особенностями лечения и бывшей профессиональной деятельности, где $p <0,05$.

Барбитураты и седативные препараты, как средство борьбы с психоневротическими состояниями, обусловленными данными состояниями, были указанны почти 2/3 больными (241/368; 66,03±3,3%), из которых 72 женщин (19,56±3,2%), включительно и в **контрольной группе (КГ)** – 48 (13,04±3,2%) и **экспериментальной группе (ЭГ)** – 24 (6,52±3,4%) – постоянно; у 169 больных (45,91±3,2%), включая КГ – 123 (33,49±2,5%) и ЭГ – 39 (31,95±3,2%) – часто. Около 1/3 заболевших РМЖ уже упоминали, что они никогда не используют или иногда (раз в полгода) барбитуровые или седативные препараты ($p<0,05$). Также мы заметили, что больные из ЭГ часто прибегают к лекарствам, чтобы вернуться к нормальной жизни, что подтверждается наличием высокого уровня злоупотребления данных лекарств (где $p<0,05$), как вредная привычка у пациенток с ЭГ по сравнению с теми из КГ.

Для личной жизни и профессиональной деятельности тех, кто страдает от РМЖ, появляются специфические трудности, личные и профессиональные проблемы.

Самые актуальные проблемы, выдвинутыми пациентами с РМЖ это: **состояние здоровья (включая психоэмоциональное)**:

у 115 п. (31,25±2,2%), включая – 41 (11,14±0,24%) из КГ и 74 (20,10±2,4%) из ЭГ, где $p<0,05$; **семейные проблемы:** у 118 п. (32,06±2,8%), включая 58 (15,75±1,56%) из КГ и 60 (16,3±1,7%) из ЭГ, где $p<0,01$; **финансовые проблемы:** у 175 п. (47,55±1,12%), включая 77 (20,93±1,7%) из КГ и 98 (26,63±3,4%) из ЭГ; **профессиональную карьеру:** у 102 п. (27,71±3,4%), включая 84 (22,82±1,2%) из КГ и 18 (4,89±1,4%) из ЭГ, где $p>0,05$. Из представленных показателей, мы выявили, что состояние психического и физического здоровья больных, страдающих от рака молочной железы в значительной степени зависит от аутогенной картины заболевания и интенсивности психо-профессионального напряжения, от обеспечения надлежащих условий, определяющих удовлетворенность жизнью и мотивации тех, кто страдает. В исследовании были использованы: Шкала Гамильтона (Hamilton Anxiety Rating Scale: HAM-A) и Шкала Спилбергера (The State-Trait Anxiety Inventory Spielberger-STAI). Оценка степени депрессии при помощи шкалы Гамильтона позволило оценить наличие и степень депрессии у пациентов с РМЖ, а также факторов, которые несут ответственность за инициирование и поддержание этого состояния. Далее мы представляем распределение показателей больных в зависимости от степени депрессии. Были получены данные: у 216 пациентов (58,69±1,3%) было выявлено **отсутствие депрессии** (ср. зн.: 5,2±0,7), включая 188 п. (50,21±2,7%) ЭГ и 28 п. (7,60±3,1%) из КГ, где $p<0,01$; у 89 п. (24,18±4,5%) – **легкая депрессия** (ср. зн.: 8,8±2,2), включая 33 п. (8,96±4,1%) из ЭГ и 56 п. (15,21±1,2%) из КГ; у 43 п. (11,68±4,8%) **– умеренная депрессия** (ср. зн.: 16,2 ±2,6), включая 18 п. (4,88±3,1%) из ЭГ и 25 п. (6,79±1,2%) из КГ, где $p<0,05$; у 20 п. (5,43±1,8%) – **выраженная депрессия** (ср. зн.: 24,4 ±4,3), включая 6 п. (1,63±3,8%) из ЭГ и 14 п. (3,80±1,5%) из КГ, где $p<0,05$.

Важно понять, что у пациентов, которые имели умеренную и выраженную степень депрессии, трудности связанные с появлением соматогенных и психосоматических проблем, которые могут негативно влиять на качество их жизнедеятельности; факторы обуславливающие депрессию у них также связанны с процессом реабилитации. Таким образом, чаще были упомянуты изнурительный режим лечения, постоянный дефицит времени, снижение возможности вернуться к работе, что в свою очередь определили уровень удовлетворенности и мотивации к жизни, отношение к семье и к социуму в целом.

Далее мы использовали в психодиагностике шкалу Спилбергера, при помощи которой смогли объективно оценить уровень реактивной и личностной тревожности у пациентов с РМЖ. В исследованных группах, распределенных в зависимости от характера медицинских карточек: **реактивная тревожность** имела близкую степень выраженности: у 151 п. (41,03±3,2%) из КГ и у 54 п.(14,67±6,7%) из ЭГ, имея низкий уровень (где, $p<0,05$); у 83 п. (22,55±1,2%) из КГ и 49 п. (13,31±4,2%) из ЭГ – средний уровень ($p>0,05$); у 12 п. (3,26±2,8%) из КГ и 19 п. (5,16±4,4%) из ЭГ – был выявлен высокий уровень реактивной тревожности (где $p<0,05$). Реактивный уровень тревожности определяется состоянием тех, кто страдает РМЖ в период наблюдения и исследования, который обусловлен влиянием тяжелого процесса в то время, также присутствием повседневных проблем, которые требуют быстрого решения. Высокий уровень личностной тревожности имеет прямо пропорциональную корреляцию с присутствием невротического конфликта, с эмоциональных и невротическими изменениями, а также с психосоматическими заболеваниями. У респондентов: 164 п. (44,56±2,3%) из КГ и 66 п. (18,02±3,1%) из ЭГ были выявлены низкий уровень личностной тревожности ($p<0,05$), а у 73 п. (19,83±4,2%) из КГ и 34 п. (9,23±4,5%) из ЭГ – умеренный ($p>0,05$) и у 10 п. (2,71±2,9%) из КГ и 20 п. (5,43±1,4%) из ЭГ – высокий уровень личностной тревожности ($p<0,05$).

По полученным данным, мы выявили следующие различия между экспериментальной (ЭГ) и контрольной группы (КГ): более высокий уровень тревожности, характерен пациентам с РМЖ с реактивной тревожностью (14,52±4,4% для ЭГ по сравнению с 4,59±2,8% для КГ, где $p<0,05$), так и для пациентов с личностной тревожностью (17,02±4,4% для ЭГ, по сравнению с 4,13±2,1% для КГ, где $p<0,05$).

Личностная тревожность характеризует постоянное стремление человека к восприятию широкого круга ситуаций как угрожающие, а впоследствии – реагировать на них, состоянием тревожности. В конечном счете, мы выявили, что контрольная группа (КГ) имеет более низкий уровень тревожности, особенно для реактивной тревожности, где $p<0,05$, так как это обусловлено состоянием болезни. Изменение обстановки, связанной с лечением, приводит к тревожности, неуверенности, депрессии и обусловливает истощение нервной и иммунной системы, снижение адаптивных возможностей, что в конечном итоге отражается на эффективности лечения и качестве жизни пациентов. Недооценка важности внутреннего мира больной, ее личностных особенностей, отношения к заболеванию и лечению, к будущему не позволяет использовать психологические ресурсы личности для приспособления к болезни и преодоления ее последствий [1, 2, 3]. В современной онкологии отмечается известная диспропорция, между усложняющимися и совершенствующимися методами специального лечения и недостаточностью знаний о характере и степени выраженности реакций со стороны психики онкологических больных [6, 8, 9].

Основной вывод из проведенных исследований, это важность целостного подхода к лечению онкозаболеваний, в контексте котором требуется исследование копинговых механизмов и разработка методологии инвентаризации качественных стратегий для улучшения жизнедеятельности и психологической адаптации больных с РМЖ. Поэтому в дальнейшем, мы рассмотрим, какие виды реакции на стресс делают человека более восприимчивым к раковым заболеваниям, а в особенности с диагнозом РМЖ.

References:

1. Burgess C., Morris T., Pettingale K.W. Psychological response to cancer diagnosis II. Evidence for coping styles. J. Psychosom. Res.: 1988, 20. pp. 795–802. https://doi.org/10.1016/0022-3999(88)90067-0

2. Losken A., Mackay G.J., Bostwick III J. Nipple Reconstruction Using the C-V Flap Technique A Long-Term Evaluation., Plast. Reconstr. Surg. 2001. Vol. 108. pp. 361-369. https://doi.org/10.1097/00006534-200108000-00013

3. Royak-Schaler R. Psychological processes in Breast Cancer. A review of selected research. In: Journal of Psychosocial Oncology. 1992., Vol. 9., Issue 4, pp. 71-89. https://doi.org/10.1300/j077v09n04_05

4. Stolbach L.L., Brandt U.C. Psychosocial factors in the development and progression of breast cancer. In: Stress and Breast cancer, Chichester, etc. 1988. pp. 3-24.

5. Arzymatova A.O. Psikhologicheskiye aspekty lecheniya bol’nykh rakom molochnoy zhelezy. Avtoreferat na soiskaniye uch. st. k. med. nauk. [Psychological aspects of treatment of patients with breast cancer. Abstract of the thesis for the Candidate of Medicine degree]. - Bishkek, 2014.

6. Davydov M.I., Aksel’ Ye.M. Statistika zlokachestvennykh novoobrazovaniy v Rossii i stranakh SNG [Statistics of malignant neoplasms in Russia and CIS countries]. – Moskva., Meditsina [Medicine], 2005. 268 p.

7. Ivanov S.V., Beskova D.A. X Mezhdunarodnyy kongress po psikhoonkologii. In: Psikhicheskiye rasstroystva v obshchey meditsine [X International Congress on Psycho-oncology. In: Mental disorders in the general medicine]. 2009. No. 1, pp. 65-67., Access mode: http://www.fesmu.ru/

8. Mishchuk Yu.Ye. Osobennosti kliniki i podkhodov k lecheniyu trevozhno-depressivnykh rasstroystv u zhenshchin, bol’nykh rakom molochnoy zhelezy, perenesshikh mastektomiyu. Avtoreferat dis. kand. med. Nauk [Features of the clinical picture and approaches to treatment of anxiety-depressive disorders in women with breast cancer, who underwent a mastectomy. Abstract of the thesis for the Candidate of Medicine degree]. – Moskva, 2008. - 24 p.

9. Chulkova V.A. Psikhologicheskoye issledovaniye lichnostnykh reaktsiy na bolezn’ pri rake molochnoy zhelezy. Avtoreferat dis. kand. psikhol. nauk. [Psychological study of personal reactions to the breast cancer disease. Abstract of the thesis for the Candidate of Psychology degree]. – Saint Petersburg., 1999. – 22 p.

Литература:

1. Burgess C., Morris T., Pettingale K. W. Psychological response to cancer diagnosis II. Evidence for coping styles. J. Psychosom. Res.: 1988, 20. p. 795–802. [PubMed] https://doi.org/10.1016/0022-3999(88)90067-0

2. Losken A., Mackay G.J., Bostwick III J. Nipple Reconstruction Using the C-V Flap Technique A Long-Term Evaluation // Plast. Reconstr. Surg. 2001. Vol. 108. pp. 361-369. https://doi.org/10.1097/00006534-200108000-00013

3. Royak-Schaler R. Psychological processes in Breast Cancer. A review of selected research. In: Journal of Psychosocial Oncology. 1992. Vol. 9. Issue 4, p. 71-89. https://doi.org/10.1300/j077v09n04_05

4. Stolbach L. L., Brandt U. C. Psychosocial factors in the development and progression of breast cancer. In: Stress and Breast cancer, Chichester, etc. 1988. p. 3-24.

5. Арзыматова А.О. Психологические аспекты лечения больных раком молочной железы. Автореферат на соискание уч. ст. к. мед. наук. Бишкек, 2014.

6. Давыдов М.И., Аксель Е.М. Статистика злокачественных новообразований в России и странах СНГ. Москва: Медицина, 2005. 268 с.

7. Иванов С.В., Бескова Д.А. X Международный конгресс по психоонкологии. In: Психические расстройства в общей медицине. 2009. № 1, стр. 65-67. http://www.fesmu.ru/

8. Мищук Ю.Е. Особенности клиники и подходов к лечению тревожно-депрессивных расстройств у женщин, больных раком молочной железы, перенесших мастэктомию. Автореферат дис. канд. мед. Наук. Москва, 2008, 24 с.

9. Чулкова В.А. Психологическое исследование личностных реакций на болезнь при раке молочной железы. Автореферат дис. канд. психол. наук. СПб., 1999, 22 с.

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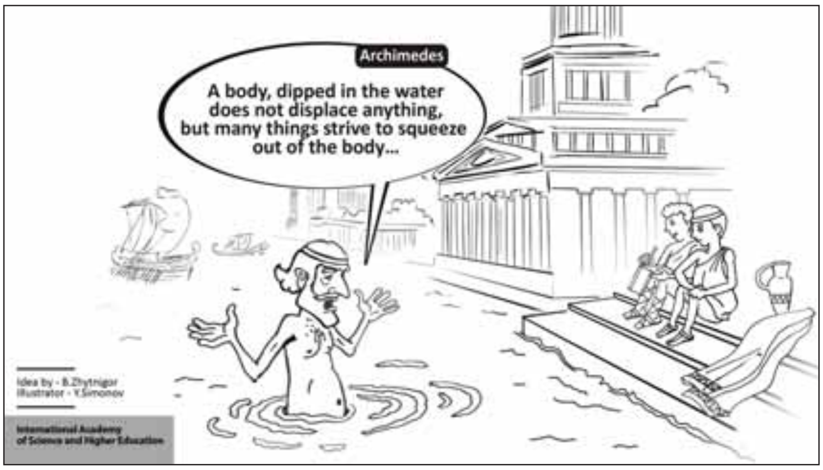
Archimedes
A body, dipped in the water does not displace anything, but many things strive to squeeze out of the body...
Idea by - B.Zhytnigor
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International Academy of Science and Higher Education

THE RESULTS OF SEXUAL REHABILITATION OF PATIENTS WITH BREAST CANCER. FULL REHABILITATION PROCESS

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Bibliographic data proves that 70% of patients with BC manifest sexual dysfunction after the disease is diagnosed. Problems include the decreased libido and low sexual satisfaction due to the patient’s concerns about own body image and menopausal symptoms, as side effects of treatment of the BC. The authors emphasize that more than 80% of patients with BC said, that they had lived a normal sex life before the diagnosis. After 2 years of diagnosis and treatment, 70% of them still reported sexual dysfunction. Most patients with sexual problems said they were concerned about their body image.

Keywords: breast cancer, endoprosthesis, rehabilitation, sex.

Conference participant

http://dx.doi.org/10.18007/gisap:msp.v0i12.1612

The scientific studies have demonstrated that radical treatment of menopause increases the risk of BC, and generates sexual dysfunction of the adjuvant endocrine. Scientists have shown that hormones, preventing recurrence of cancer after surgery, can negatively influence sexual life of patients with BC.

After the diagnosis and treatment of BC sexuality is damaged. The patients attest that breast removal inhibits feelings of both partners. Over 50% of the tested patients had sexual disorders after one year since the surgery. Scientific analysis shows that frequency of sexual acts is different at different ages: 7 times per month for couples of patients aged 30-40, 6 times per month for patients aged 40-50, and less in case of patients over 50-60. After 70 the sexuality is obviously diminished. Some authors developed recommendations for sexual life of patients with BC. They appeared in literature and pamphlets entitled “Sex life after BC”, “Sex after breast cancer”.

In the last decades mortality caused by breast cancer has increased to 24.92% in Moldova, with a share of oncological morbidity within the structure at 21.2%. Currently, from among patients treated radically (including mastectomies), 6098 require endoprosthesis.

Treatment of patients with BC has radical impact on both physiological self-image and physical appearance, and leads to the disappointment and loss of feminine identity, changes in family relations (including sexual), changes in psychological, physical and occupational self-confidence, subsequent integration and social difficulties. It causes isolation during the radical treatment, anxiety induced by thoughts about recurrence, dependence on the family and the physician, economic risks for a husband, changes in the body image; absence of breast leads to serious disorders of sexual relations within the couple. This concerns both partners. During radical treatment 86% of wives reject their partners.

Tab. 1.

The phases of sexual response in the patients with BC

	Phases	Sexual Disorder
I.	**Sexual desire**	Poor sexual motivation, minimal excitation, lack of sexual fantasies and desires. Neuroendocrine composition and individual experience are both included. The stimuli in these conditions have no strength to cause the desire.
II.	**Excitation**	Physical: touches, kisses. In the absence of mammary gland in patients lack of sexual desire is observed. All sexual desire factors are inhibited: sensory, tactile, and psychological.
III.	**Plateau**	Tensed period during the sexual processes is reduced in the BC patients with no CM. Sexual feminine processes are inhibited due to anatomical defects and breast absence. This led to expectations of orgasm.
IV.	**Orgasm**	Involuntary orgasm in patients with BC is rare.
V.	**Resolution**	Returning of sexual organ is faster.

Tab. 2.

The causes of sexual dysfunction in patients with BC

Causes	**Specified risk factors**	**Common symptoms**	**Patients**	
			c.a.	**%**
Psychological	Stress after mastectomy	Libido decrease, sexual dysfunction in the sexual excitation phase, absence of orgasm	10	50
Neurological and cardiac	Pathology of SNC and peripheral nervous system, arterial hypertension	Absence of orgasm	5	25
Endocrine and metabolic	Hormonal dysfunction, hormonal therapy and diabetic consequences.	Libido decrease	3	15
Other causes	Muscular, vascular, other causes	Decrease of vaginal lubrication, Dyspareunia.	2	10
Total	**-**	**-**	**20**	**100**

Tab. 3.

Sexual disorders in the patients with BC

Sexual disorders	**Patients**		**The integral rehabilitation steps**							
	c.a.	**%**	Diagnostic step		Treatment step		Rehabilitation step (phase)			
			c.a.	%	c.a.	%	c.a.	%	c.a.	%
The decrease of libido	44	44	44	44	44	44	28	28	18	18
Arousal deregulation	22	22	22	22	19	19	15	15	12	12
Orgasmic dysfunction	21	21	21	21	18	18	15	15	11	11
Dyspareunia	10	10	10	10	8	8	6	6	5	5
Vaginismus	3	3	3	3	3	3	3	3	3	3
Total	**100**	**100**	**100**	**20**	**100**	**20**	**67**	**13,4**	**49**	**9,8**

Relevance of the problem: high frequency of sexual disorders in the patients with BC is mentioned in various works; absence of researches in this area substantiates the need for this premiere investigation.

Purpose of the research: study of sexual disorders within the couples of patients suffering from BC during the entire rehabilitation process.

Research Methods. We have studied 20 couples in which the wife with BC was a subject of radical treatment, including mastectomy and rehabilitation surgery - breast reconstruction. We have investigated the steps which caused sexual dysfunction, sexual disorders and their correction during rehabilitation stages, sexual satisfaction of women with BC and her husband in a couple.

The research was carried out at different stages of treatment: after 6 months, 1 year, 2 years of radical treatment and the entire rehabilitation process. We have studied the phases of sexual response in the patients with BC.

Research has determined that the patients with BC sexual disorder can be attested in all phases of sexual response. The causes of sexual dysfunction of the patients with BC have been studied.

Present research has shown sexual disorders at different stages of sexual response in patients with breast cancer. First sexual desire or phase is minimal at this stage; motivation and arousal are poor, as well as sexual fantasies. Phase of excitation is diminished; poor response to physical arousal, touch, or kiss and touch – all the factors. Thus sensors are psychologically inhibited.

Plateau – phase which is equally reduced in patients with breast cancer – is caused by both lack of

Tab. 4.

Sexual satisfaction in couples engaged in the radical program of treatment and integral rehabilitation

Treatment and reha-bilitation	Radical treatment without RM								Radical treatment, and rehabilitation, integral RM								Patients number	
	Couple life satisfaction								Couple life satisfaction									
The length of time after treatment	Women with BC				The man, the patient's husband				Women with BC				The man, the patient's husband					
	No		Yes		No		Yes		No		Yes		No		Yes			
	c.a.	%	c.a.	%	c.a	%	c.a	%	c.a	%	c.a	%	c.a.	%	C.a.	%	c.a	%
The radical treatment period	20	100	0	0	20	100	0	0	20	0	0	0	20	100	0	0	20	100
6 months after treatment	10	50	10	50	8	40	12	60	5	25	15	75	6	30	14	70	20	100
1 year after treatment	9	45	11	55	10	50	10	50	10	50	10	50	9	45	11	55	20	100
2 years after treatment	8	40	12	60	10	50	10	50	10	50	8	40	12	60	10	50	20	100

(p> 0.05)

breast aesthetics (look) and aesthetic discomfort. Orgasmic phase – involuntary sexual climax, is rare. Phase of resolution – the fastest return of the sexual organ.

Our research has established that sexual dysfunction in patients with the breast cancer has different causes, namely – psychological symptoms are leading to frequent decrease in libido, and sexual arousal dysfunction. Phase I, lack of orgasm, makes up to 50% - the vast majority; neurological and cardiac symptoms, such as a lack of orgasm, are faced by up to 25% of patients; the endocrine and metabolic causes and symptoms that decrease libido in 15% of sick persons; other causes of sexual dysfunction with symptoms like the reduced vaginal lubrication, dyspareunia – 10% .

Research has determined that the patients with BC during the rehabilitation process at different stages have different sexual disorders. In the diagnostic phase libido disorders were common in 44% cases; in the treatment step this index increased to 52%; in the step after the breast resection this index decreased to 18% cases. Another trend was shown by the arousal disorders phase: 22% at the stage of diagnosis, which later decreased to 15% and 12% consecutively. The same trend was observed in organ dysfunction and dyspareunia: 15% and 5% correspondingly. Vaginismus did not change.

Conclusions

Our investigation had determined that during the radical treatment stage sexual relations are missing, and life dissatisfaction in this period is absolute. Its length is 6.0 ± 1 weeks ($p > 0.05$). In 6 months after the radical treatment, sexual relations in couple are restored, but 50% of women with BC, and 40% of their husbands are not satisfied with couple relationships (10-15% of which are restored during the entire rehabilitation period). Both, after 1 and 2 years after the radical treatment, improvement of the status of the couple sexual life was registered; satisfaction reached up to 55% ($p > 0.05$).

Our research aimed to study sexual rehabilitation of patients with breast cancer at various stages of rehabilitation. Our study showed the following significant results: the phases of sexual response in all affected manifestly meant the steps of sexual disorder; the causes and risk factors of sexual dysfunction are at most affected psychologically – 50%, cardiac, neurologic causes – 25 %, endocrine and metabolic causes – 15%, and other causes – 10%.

The most common symptoms are related to the decreased libido, arousal dysfunction, lack of orgasm, decreased vaginal lubrication, dyspareunia. Sexual disorders are also modifying the rehabilitation phase at all stages of diagnostics, inpatient treatment and rehabilitation.

Partial elimination of sexual disorders (but not 100%) led to satisfaction of the sexual partner of the patient as well. Thus, we underline the importance of rehabilitation of patients at all stages of the breast cancer treatment. Sexual rehabilitation is very important, as well as the breast endoprosthesis replacement, aesthetic, anatomical, and psychological rehabilitation, psychological and financial support, rehabilitation and assistance in job seeking.

References:

1. Agarwal S., Liu J.H., Crisera C.A., Buys S., Agarwal J.P.. Survival in breast cancer patients undergoing immediate breast reconstruction. Breast J. 2010 Sep-Oct;16(5):503-9. Epub 2010 Jun 29. https://doi.org/10.1111/j.1524-4741.2010.00958.x

2. Agha-Mohammadi S. De La Cruz C. Hurwitz D.J. Breast reconstruction with alloplastic implants. J. Surg. Oncol. 2006 Nov 1; 94(6): 471-8. https://doi.org/10.1002/jso.20484

3. Arroyo, J.M.G., López, M.L.D. Psychological Problems Derived from Mastectomy: A Qualitative Study. International Journal of Surgical Oncology, 2011. https://doi.org/10.1155/2011/132461

4. Bellino S., Fenocchio M., Zizza M., Rocca G., Bogetti P., Bogetto F. Quality of life of patients who undergo breast reconstruction after mastectomy: effects of personality characteristics. Plast-ReconstrSurg. 2011 Jan; 127(1): 10-7. https://doi.org/10.1097/prs.0b013e3181f956c0

5. Butow P.N. Psychosocial predictors of survival: metastatic breast cancer., P.N. Butow, A.S. Coates, S.M. Dunn., Ann. Oncol. 2000. - Vol. 11., pp. 469-474. https://doi.org/10.1016/s0960-9776(16)30029-7

6. Carpenter P.J., Norrow G.R., Schmale A.H. The psychosocial status of cancer patients after cessation of treatment., J. Psyphosoc. Oncol. - 1989., Vol. 7, No. 1-2., pp. 95-103. https://doi.org/10.1300/j077v07n01_07

7. Copper C.L. Psychosocial stress and breast cancer: the interrelationship between stress events, coping strategies and personality., C.L. Copper, E.B. Faragher., Psychol. Med. 1993. - Vol. 23., pp. 653-662. https://doi.org/10.1017/s0033291700025435

8. Coryell W.H., Zimmerman M. Personality disorder in the families of depressed, schizophrenic and never-ill probands., Ibid. - 1989., Vol. 146., pp. 496-502. https://doi.org/10.1521/pedi.1989.3.1.53

9. deHses I.C.I. ML, Welvart K. Quality of life after breast cancer surgery., J. Surg. Oncol. - 1985., Vol. 28., pp. 123. https://doi.org/10.1002/jso.2930280211

10. Ferrel B.R., Grant M., Funk B., Scaffner M.L. Quality of Life in breast cancer., Cancer Pract. 1996. - Vol. 4, No. 6., pp. 331-340. https://doi.org/10.1097/00002820-199802000-00001

11. Holmberg L., Omne-Ponten M., Burns T et. al. Psychosocial adjustment after mastectomy and breast-conserving treatment., Cancer. - 1989., Vol. 64., No. 4., pp. 969-974. https://doi.org/10.1002/1097-0142(19890815)64:4<969::aidcncr2820640433>3.0.co;2-o

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PHARMACEUTICAL LAW IN THE REGULATORY SYSTEM OF CIRCULATION OF MEDICINES OF VARIOUS CLASSIFICATION-LEGAL AND NOMENCLATURE-LEGAL GROUPS IN UKRAINE

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The authors analyse the regulatory system of legal circulation of medicines of different legal-classification groups and legal-nomenclature groups in the European Union and in Ukraine from the standpoint of the pharmaceutical law.

Keywords: pharmaceutical law, legal circulation of medicines, legal-classification group, legal-nomenclature group.

Conference participants

УДК 342.951:[61+615]+615.1

ФАРМАЦЕВТИЧЕСКОЕ ПРАВО В РЕГУЛЯТОРНОЙ СИСТЕМЕ ОБОРОТА ЛЕКАРСТВЕННЫХ СРЕДСТВ РАЗЛИЧНЫХ КЛАССИФИКАЦИОННО-ПРАВОВЫХ И НОМЕНКЛАТУРНО-ПРАВОВЫХ ГРУПП В УКРАИНЕ

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В статье проведен анализ регуляторной системы оборота лекарственных средств различных классификационно-правовых и номенклатурно-правовых групп в Европейском союзе и Украине с позиции фармацевтического права.

Ключевые слова: фармацевтическое право, оборот лекарственных средств, классификационно-правовая группа, номенклатурно-правовая группа.

Участники конференции

http://dx.doi.org/10.18007/gisap:msp.v0i12.1613

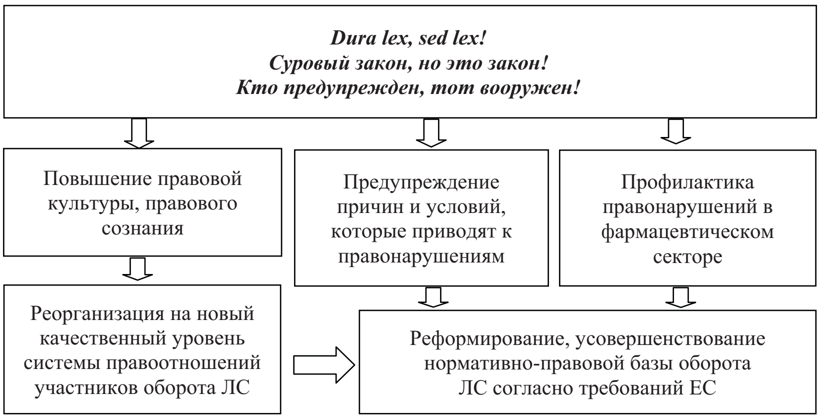
Dura lex, sed lex!
Суровый закон, но это закон!
Кто предупрежден, тот вооружен!
Повышение правовой культуры, правового сознания
Предупреждение причин и условий, которые приводят к правонарушениям
Профилактика правонарушений в фармацевтическом секторе
Реорганизация на новый качественный уровень системы правоотношений участников оборота ЛС
Реформирование, усовершенствование нормативно-правовой базы оборота ЛС согласно требований ЕС

Рис. 1. Задачи фармацевтического права

Сегодня адаптация отечественного законодательства к европейским стандартам является важным условием интеграции Украины в Европейский Союз (ЕС). Для формирования правового мышления, правосознания, правовой культуры специалистов фармации и медицины необходимо постоянно усовершенствовать систему правоотношений «врач - пациент – провизор – контролирующие, правоохранительные и адвокатские органы». Трансформация украинского общества к цивилизованным формам и демократическим институтам ЕС сопровождается формированием прозрачного правового поля, которое способствует защите прав и свобод, воли, здоровья и жизни граждан, пациентов, провизоров и врачей. Поэтому современная концепция верховенства фармацевтического права (которое включает в себя элементы конституционного, гражданского, гражданско-процессуального, финансового, уголовного, уголовно-процессуального, административного, таможенного, международного, судебно-фармацевтического, земельного, трудового, семейного, налогового и др.) занимает одно из приоритетных мест среди других социально значимых проблем и находится в центре обсуждения научно-фармацевтического, медицинского и правоведческого содружества [1, 2, 12, 14].

Целью исследования стало изучение регуляторной системы оборота лекарственных средств различных классификационно-правовых и номенклатурно-правовых групп в Украине на основе фармацевтического права.

Для проведения исследования были использованы следующие *материалы и методы исследования*: действующие нормативно-правовые документы и данные Интернет-ресурсов ЕС и Украины [1, 3, 6, 9, 11, 17]. Использовались: нормативно-правовой, документальный, сравнительный и графический методы анализа

Результаты исследования и их обсуждения. В наших предыдущих исследованиях было введено в научный оборот содержательное наполнение термина фармацевтическое право, как мера свободы, равенства и справедливости, выраженная в системе формально-определенных и охраняемых публичной властью общеобязательных норм поведения и деятельности субъектов, которые возникают в результате реализации конституционного права на медицинскую и фармацевтическую деятельность [9, 12, 17].

Задачи ФП представлены на рис. 1.

Для качественного выполнения поставленных задач ФП тесно сотрудничает с другими дисциплинами медицинской и юридической направленности, что характеризует междисциплинарный характер ФП и представлено на рис. 2. Фармацевтическое право включает три составляющие: медицинское и фармацевтическое законодательство, судебная фармация и доказательная фармация. Фармацевтическое право (ФП), как отрасль права, представляет совокупность научных знаний о фармацевтическом законодательстве (ФЗ) и практике его применения. ФП отличается от основных отраслей права тем, что это комплексная отрасль, в которой согласовываются нормы различных отраслей права с целью их совместного применения в сфере фармации. ФП, как отрасль законодательства – это совокупность нормативно-правовых актов, которые регулируют общественные отношения в сфере фармации [9, 12, 17, 18].

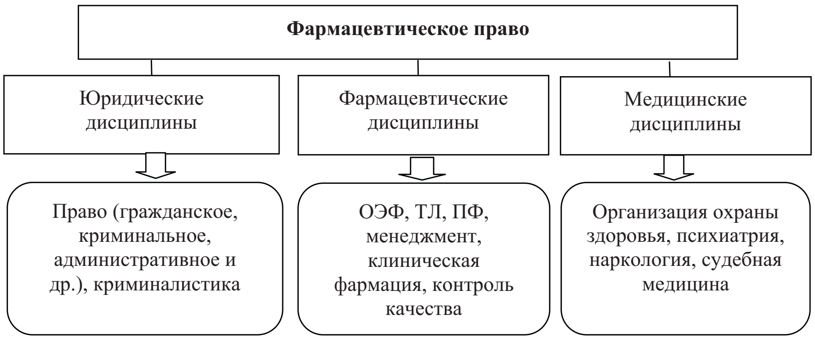
Фармацевтическое право
Юридические дисциплины
Фармацевтические дисциплины
Медицинские дисциплины
Право (гражданское, криминальное, административное и др.), криминалистика
ОЭФ, ТЛ, ПФ, менеджмент, клиническая фармация, контроль качества
Организация охраны здоровья, психиатрия, наркология, судебная медицина

Рис. 2. Междисциплинарный характер фармацевтического права

Регуляторная система оборота лекарственных средств (ЛС) координирует работу фармацевтического сектора с 2 сторон: 1) правовая фармация – составляющая ФП, изучающая легальный оборот ЛС; 2) судебная фармация – составляющая ФП, изучающая причины и условия, которые приводят к правонарушениям в фармацевтическом и медицинском секторе, а также нелегальный оборот ЛС различных классификационно-правовых групп (КПГ) и номенклатурно-правовых групп (НПГ) с целью их профилактики и предупреждения [7, 9, 11, 15].

Более детально составляющие ФП в регуляторной системе оборота ЛС представлены на рис. 3.

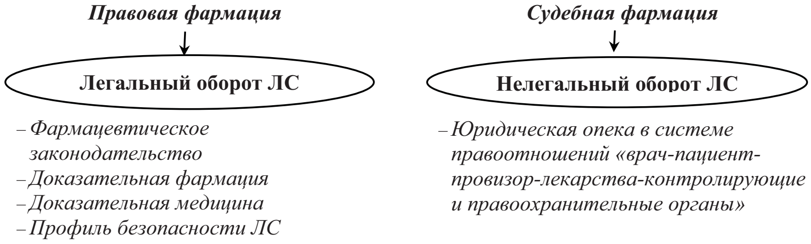
Правовая фармация
Судебная фармация
Легальный оборот ЛС
Нелегальный оборот ЛС
– Фармацевтическое законодательство
– Доказательная фармация
– Доказательная медицина
– Профиль безопасности ЛС
– Юридическая опека в системе правоотношений «врач-пациент-провизор-лекарства-контролирующие и правоохранительные органы»

Рис. 3. Составляющие фармацевтического права в регуляторной системе оборота лекарственных средств различных классификационно-правовых и номенклатурно-правовых групп

Следует отметить, что регуляторная система легального оборота ЛС различных КПГ и НПГ включает более 10 этапов оборота (рис. 4) [8, 9, 11, 13].

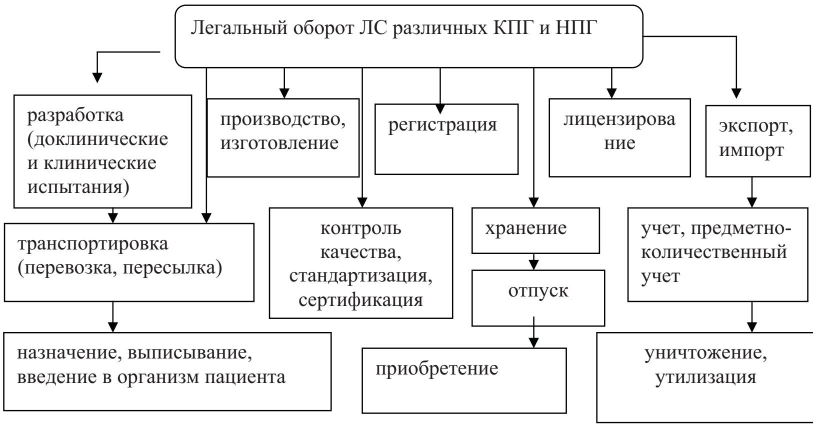
Легальный оборот ЛС различных КПГ и НПГ
разработка (доклинические и клинические испытания)
производство, изготовление
регистрация
лицензирование
экспорт, импорт
транспортировка (перевозка, пересылка)
контроль качества, стандартизация, сертификация
хранение
отпуск
учет, предметно-количественный учет
назначение, выписывание, введение в организм пациента
приобретение
уничтожение, утилизация

Рис. 4. Регуляторная система легального оборота лекарственных средств различных классификационно-правовых и номенклатурно-правовых групп в Украине

В ходе проведения исследований авторы использовали инструмент режима контроля (РК) ЛС, под которым подразумеваются требования законодательных, нормативно-правовых и инструктивно-методических документов к клинико-фармакологической, классификационно-правовой и номенклатурно-правовой характеристике ЛС [9, 11].

РК: КФГ → КПГ → НПГ, где РК – режим контроля; КФГ – клинико-фармакологическая группа; КПГ – классификационно-правовая группа; НПГ – номенклатурно-правовая группа.

Классификационно-правовая группа – это группа, которая указывает на профиль безопасности ЛС при действии на организм пациента [9, 11]. Далее приведены основные КПГ ЛС в регуляторной системе их оборота на фармацевтическом рынке (рис. 5).

Номенклатурно-правовая группа ЛС – это группа, которая указывает на форму отпуска ЛС. По форме отпуска все ЛС делятся на рецептурные и безрецептурные [9, 11].

Далее представляло интерес проанализировать НПГ и критерии определения категорий отпуска ЛС в ЕС и Украине. В ЕС, как в Украине, существуют две НПГ ЛС: рецептурная и безрецептурная. Рецептурная НПГ ЛС предусматривает отпуск ЛС по специальным рецептам, одноразовым рецептам, многоразовым рецептам, а также отпуск ЛС с ограниченной областью. В настоящее время в ЕС

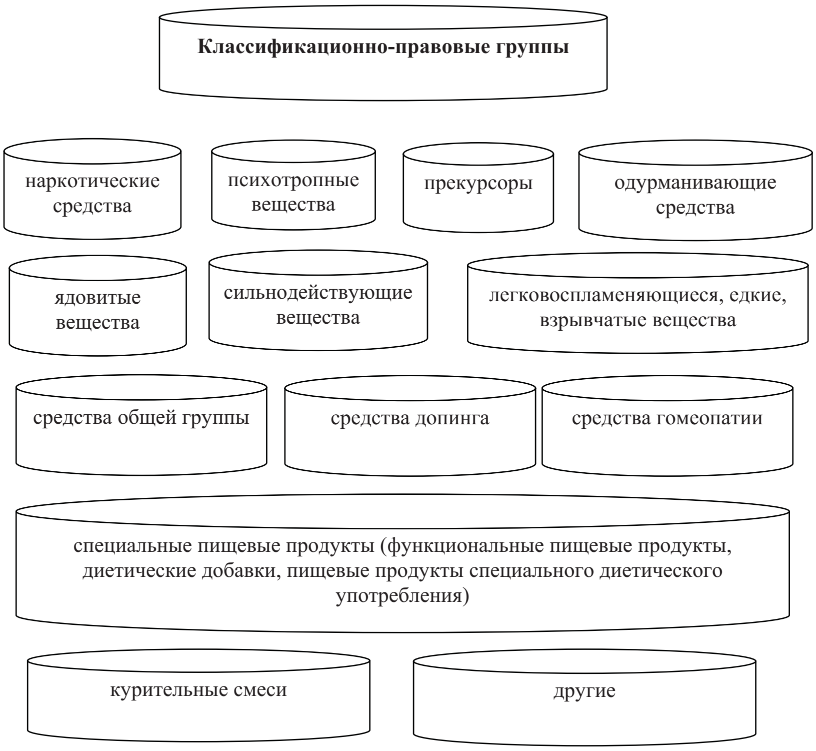
Классификационно-правовые группы
наркотические средства
психотропные вещества
прекурсоры
одурманивающие средства
ядовитые вещества
сильнодействующие вещества
легковоспламеняющиеся, едкие, взрывчатые вещества
средства общей группы
средства допинга
средства гомеопатии
специальные пищевые продукты (функциональные пищевые продукты, диетические добавки, пищевые продукты специального диетического употребления)
курительные смеси
другие

Рис. 5. Классификационно-правовые группы лекарственных средств в регуляторной системе оборота

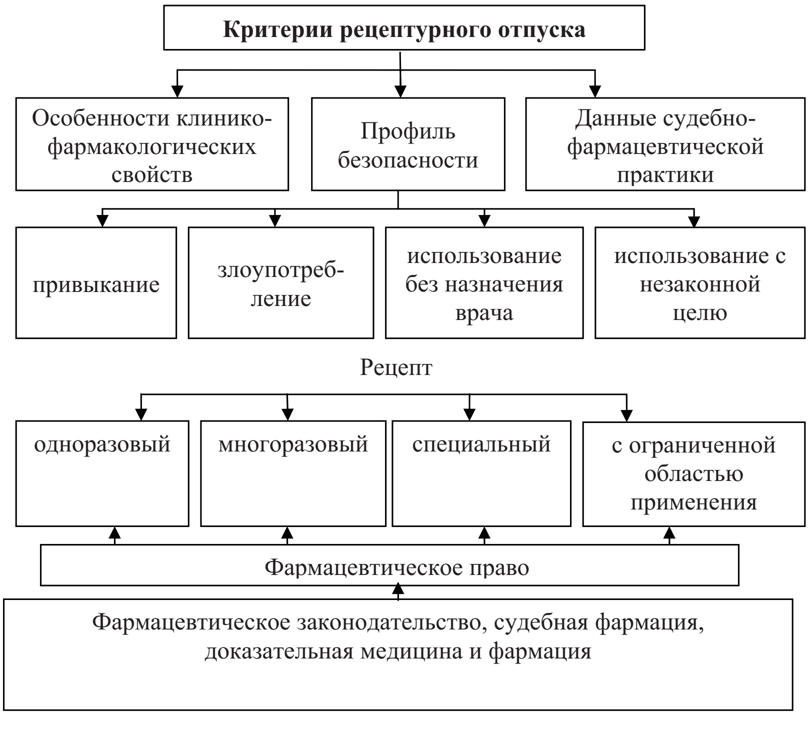
Критерии рецептурного отпуска
Особенности клинико-фармакологических свойств
Профиль безопасности
Данные судебно-фармацевтической практики
привыкание
злоупотреб-ление
использование без назначения врача
использование с незаконной целю
Рецепт
одноразовый
многоразовый
специальный
с ограниченной областью применения
Фармацевтическое право
Фармацевтическое законодательство, судебная фармация, доказательная медицина и фармация

Рис. 6. Критерии рецептурного отпуска лекарственных средств в Украине с позиции фармацевтического права

действует Директива №92/26/ЕС от 31.03.1992 г. (далее Директива), в которой приводятся четкие критерии, разграничивающие формы отпуска ЛС. Соответствии с данной Директивы к критериям отнесения ЛС к категории рецептурного отпуска относятся: 1) ЛС, которые могут представлять опасность для здоровья людей даже в случае их правильного применения, но без медицинского наблюдения; 2) ЛС, которые в силу заблуждений широко применяются неправильно или содержат субстанции, требующие дальнейшего клинического изучения; 3) ЛС, применяемые парентерально и недавно выведенные на фармацевтический рынок. Все остальные ЛС относятся к безрецептурным [1, 2].

В Украине согласно действующего ФЗ [3] ЛС делятся на две категории: 1) ЛС, которые отпускаются по рецепту (например, наркотические, психотропные, сильнодействующие, ядовитые ЛС и ЛС-прекурсоры; 2) ЛС, которые отпускаются без рецепта (например, комбинированные (многокомпонентные) и однокомпонентные ЛС). В свою очередь, ЛС, отпускаемые по рецепту, могут быть разделены на отдельные группы согласно такой классификации: 1) ЛС, которые отпускаются по разовым или многократными рецептам; 2) ЛС, которые отпускаются по специальным рецептам; 3) ЛС, которые отпускаются по рецептам и имеют ограниченную область применения. ЛС относятся к рецептурной категории (отпускаются по разовому или многоразовому рецепту) в случае, когда: 1) ЛС представляют угрозу для здоровья потребителя даже при правильном применении, но без медицинского наблюдения (психоактивные вещества); 2) ЛС используется многими потребителями неправильно (антибиотики); 3) ЛС содержит вещество, действие и побочные эффекты которого требуют дальнейшего изучения (комбинированные ЛС); 4) ЛС предназначено для парентерального введения. Отпуск ЛС по специальным рецептам осуществляется в 3-х случаях, когда: 1) ЛС отнесено к наркотическим средствам или психотропным веществам согласно действующего законодательства; 2) ЛС при неправильном употреблении представляет существенный риск (злоупотребление, привыкание, использование в незаконных целях); 3) ЛС содержит вещество, которое вследствие его новизны или фармакологических свойств можно отнести к данной группе; 4) ЛС содержит в своем составе вещества отнесенные к прекурсорам [1, 6, 14].

Отнесение ЛС к ограниченной области применения происходит в 3-х случаях, когда: 1) ЛС благодаря своим фармакологическим свойствам, новизне и в интересах сохранности здоровья пациента применяется только в условиях стационара; 2) ЛС применяется для лечения заболеваний, диагноз которых может быть установлен в условиях стационара или в учреждениях, которые имеют необходимое диагностическое оборудование, хотя приём ЛС и дальнейшее наблюдение могут проводиться в других условиях; 3) ЛС предназначено для амбулаторного лечения пациентов, но его применение может привести к серьёзным побочным эффектам, в результате чего необходимы рецепт и контроль со стороны врача на протяжении всего периода лечения [5, 16].

ЛС отпускаются без рецепта в случае, когда: 1) ЛС не отнесены к рецептурным; 2) ЛС содержат малые количества наркотических средств, психотропных веществ и прекурсоров, и эти средства или вещества не могут быть извлечены из ЛС легкодоступными способами в количествах, позволяющих злоупотреблять ими [10].

Таким образом, критерии рецептурного отпуска ЛС из аптечных учреждений Украины приведены на рис. 6.

Критериями безрецептурного отпуска ЛС являются особенности клинико-фармакологических свойств, минимальные или редкие случаи побочного действия, доказанный профиль безопасности.

Таким образом, изучение фармацевтического права способствует повышению правосознания, правовой культуры, правового мышления специалистов фармации и медицины, отвечает современным требованиям по предупреждению, профилактике причин и условий, которые вызывают коррупцию, преступность и другие правонарушения, связанные с оборотом ЛС (например, наркотических средств, психотропных веществ, прекурсоров, сильнодействующих и ядовитых веществ и др.), а также помогает защитить права и свободы, жизни и здоровье пациентов при предоставлении медицинской помощи и фармацевтического обеспечения. Фармацевтическое право, как самостоятельное направление в фармации и медицине, взаимно обогащает научные медицинские и фармацевтические дисциплины. Проведенный анализ регуляторной системы оборота ЛС в ЕС и Украине показал, что ситуация с соблюдением форм отпуска ЛС в Украине далека от идеальной. При этом одним из реальных шагов к наведению порядка в сфере оборота рецептурных и безрецептурных ЛС может быть разработка и утверждение критериев отнесения ЛС к категории рецептурных и безрецептурных, а также формирование и утверждение списков безрецептурных и рецептурных ЛС на постоянной основе.

References:

1. Direktiva 98/26/ES «Ob opredelenii kategoriy lekarstvennykh preparatov dlya cheloveka» ot [98/26/EC Directive «On the determination of categories of medicines for human beings» dated]., 31.03.1992.., Access mode: http://zakon0.rada.gov.ua/laws/show/z0464-01.

2. Klevtsova L. Osobennosti funktsionirovaniya na rynke preparatov bezretsepturnogo otpuska [Features of functioning of non-prescription drugs in the market]., L. Klevtsova., Moskovskiye apteki [Moscow pharmacies]. – 2003., No. 5., Access mode: http://rudoctor.net/medicine2009/bz-jw/med-kmnaf.htm.

3. Nakaz Mínísterstva okhoroni zdorov’ya Ukraíïni víd 17.05.2001. No. 185 «Pro zatverdzhennya kriteríïïv viznachennya kategoríy vídpusku líkars’kikh zasobív» [Decree of the Ministry of Health of Ukraine of 17/05/2001. No. 185 «On approval of criteria of determination of categories of dispensing the drugs»]., Access mode: http://zakon0.rada.gov.ua/laws/show/z0464-01.

4. Nevolina Ye.V. Vmesto konkurentsii – diskriminatsiya: budet dve sistemy otpuska lekarstv [Instead of competition - discrimination: there will be two systems of dispensing the drugs].,Ye.V. Nevolina., Moskovskiye apteki. [Moscow pharmacies]. – 2013., No. 6., Access mode: http://www.aptekiguild.ru/press?id=204

5. Organízatsíyno-pravoví osoblivostí poryadku obígu okremikh klasifíkatsíyno-pravovikh grup kontrol’ovanikh líkars’kikh zasobív v Ukraíïní na zasadakh farmatsevtichnogo prava [Organizational and legal peculiarities of circulation of separate classification and legal groups of controlled drugs in Ukraine on the basis of the pharmaceutical law]., V.V. Shapovalov (mol.), L.O. Komar, V.O. Shapovalova, V.V. Shapovalov., Klíníchna farmatsíya, farmakoterapíya ta medichna standartizatsíya [Clinical Pharmacy, Pharmacotherapy and Medical Standardization]. – 2015., No. 1-2 (26-27)., pp. 61–68.

6. Postanova Kabínetu Mínístrív Ukraíïni víd 06.05.2000 r. № 770 «Pro zatverdzhennya perelíku narkotichnikh zasobív, psikhotropnikh rechovin í prekursorív» [The Decree of the Cabinet of Ministers of Ukraine of 06/05/2000. No. 770 «On approval of the list of narcotic drugs, psychotropic substances and precursors»]., Access mode: http://zakon2.rada.gov.ua/laws/show/770-2000-p.

7. Sudebno-farmatsevticheskaya kharakteristika pravonarusheniy v sfere oborota sredstv i veshchestv razlichnykh klassifikatsionno-pravovykh grupp [Forensic and pharmaceutical characteristics of offenses in the sphere of turnover of drugs and substances of various classification and legal groups]., V.V. Shapovalov (ml.), V.V. Shapovalov, S.I. Zbrozhek, V.A. Shapovalova, L.A. Komar., Farmatsiya Kazakhstana [Pharmacy of Kazakhstan]. – 2015., No. 3 (166)., pp. 46–50.

8. Sudovo-farmatsevtichne vivchennya porushen’ obígu kontrol’ovanikh líkars’kikh zasobív v zakladakh okhoroni zdorov’ya síl’s’koíï místsevostí [Forensic and pharmaceutical study of violations of circulation of controlled medicines in healthcare facilities in rural areas]., Yu.V. Vasína, V.V. Shapovalov, V.O. Shapovalova, M.O. Khmelevs’kiy., Sbornik nauchnykh trudov [Collection of scientific works] SWorld. – Ivanovo., Markova A.D., 2014. – ISSN 2224-0187.,Vol. 30, Issue. 3 (36)., pp. 59–70.

9. Farmatsevticheskoye i meditsinskoye pravo: uch. posob. (seriya: Farmatsevticheskoye pravo)

[Pharmaceutical and medical law: tutorial (Series: Pharmaceutical Law)]., V.V. Shapovalov, V.V. Shapovalov (ml.), V.A. Shapovalova; ed. by V.V. Shapovalova. – [1-st ed.]. – Kharkiv., «Skorpion» Publishing, 2011. – 208 p.

10. Farmatsevticheskoye pravo v bezopasnom samolechenii. Lekarstvennyyesredstva,kotoryyeotpuskayutsya bez retsepta vracha [Pharmaceutical law in safe self-medication. Medicines, which are dispensed without a doctor's prescription]., V.A. Shapovalova, V.V. Shapovalov, N.N. Khalin i dr. – Kharkov., Skorpion, 2010. – 1200 p.

11. Farmatsevtichne pravo ta sudova farmatsíya: slovnik termínív [Pharmaceutical law and forensic pharmacy: dictionary of terms]., V.O. Shapovalova, V.V. Shapovalov, O.S. Abrosimov, Í.K. Sosín, O.Ê. Virva, M.M. Khalín, Z.S. Galavan, O.V. Danílyuk, O.Í. Gutorov, O.V. Vereshchak, T.V. Kuznetsova, S.V. Pastalitsya, G.M. Vishar, L.O. Gutorova, Val.V. Shapovalov, V.V. Bondarenko, V.O. Petrenko, O.P. Zamoshets', N.G. Malínína, S.Í. Zbrozhek, V.V. Kolyada, S.A. Yashchenko, A.G. Yakubovs'ka., Farmatsevtichne pravo v sistemí pravovídnosin: virobnik – líkar – patsíênt – provízor – líki – kontrolyuyuchí ta pravookhoronní organi: Mat. nauk.-prakt. konf.–Líki Ukraíïni [Pharmaceutical Law in the system of legal relations: manufacturer - doctor - patient - pharmacist - drugs - regulatory and law enforcement agencies, Materials of the scientific and practical conference "Medicines of Ukraine"]. – 2005., No. 9 (app)., pp. 213–236.

12. Shapovalov V.V. Vvedeniye v meditsinskoye, farmatsevticheskoye pravo i sudebnuyu farmatsiyu [Introduction to medical, pharmaceutical law and forensic pharmacy]., V.V. Shapovalov, V.V. Shapovalov (ml.), V.A. Shapovalova., Pravo i etika biomeditsinskoy deyatel'nosti v Rossii i za rubezhom : sb. nauch. st. [Law and ethics in biomedical activities in Russia and abroad: Collection of scientific papers] – Penza., PSU Publishing, 2014. – ISBN 978-5-94170-857-4., pp. 186–194.

13. Shapovalov V.V. Mízhnarodna spívpratsya Ukraíïni z protidíïí organízovaníy narkozlochinností, narkotrafíku í kontrabandí narkotichnikh zasobív na zasadakh sudovoíï farmatsíïí ta kriminalístiki [International cooperation of Ukraine aimed at combating the organized drug production, trafficking and smuggling of drugs, based on forensic pharmacy and criminology] [Electronic resource]., V.V. Shapovalov., Teoríya í praktika pravoznavstva [Theory and practice of Law]. – 2014. – Issue. 1(5)., ISSN 2225-6555., pp. 1–26., Access mode: http://nauka.jur-academy.kharkov.ua/download/el_zbirnik/1.2014/11.5.pdf. https://doi.org/10.18413/2313-8955-2015-1-1-30-50

14. Shapovalov V.V. Yuridichna opíka spetsíalístív meditsini ta farmatsíïí v sistemí pravovídnosin «líkar – patsíênt – provízor – advokat – kontrolyuyuchí ta pravookhoronní organi»., V.V. Shapovalov., Dosudove slídstvo, farmatsevtichne í medichne pravo, yak skladoví derzhavnoíï polítiki Ukraíïni u protidíïí narkozlochinností ta poshirennyu narkomaníïí: víd polítseys'koíï khímíïí í sudovoíï farmatsíïí do farmatsevtichnogo í medichnogo zakonodavstva, sotsíal'noíï, dokazovoíï meditsini í farmatsíïí: materíali VÍÍI Mízhnar. nauk.-prakt. konf. (18–19 listopada 2011 r., m. Kharkív) [Legal custody of experts in medicine and pharmaceutics within the system of relations: «doctor - patient - pharmacist - lawyer - regulatory and law enforcement agencies.» V.V. Shapovalov., Prejudicial inquiry, pharmaceutical and medical law as the elements of the state policy of Ukraine in combating the spread of drug abuse and drug crime: from police chemistry and forensic pharmacy to the pharmacy and medical law, social, evidence-based medicine and pharmacy. Materials of the VIII International scientific and practical conference (November 18-19, 2011, Kharkiv)] – Kharkiv., 2011. – [Section 2]., pp. 246–268.

15. Shapovalov V.V. Sudovo-farmatsevtichne vivchennya problemi zlovzhivannya ta vídpratsyuvannya pravovikh printsipív skorochennya popitu na psikhoaktivní rechovini ríznikh klasifíkatsíyno-pravovikh grup [Forensic and pharmaceutical examination of the issue of abuse and development of the legal principles of reduction of the demand for psychoactive substances of various legal classification groups]., V.V. Shapovalov., Farmatsevtichniy zhurnal [Pharmaceutical Journal]. – 2014., No. 2., pp. 39–47. https://doi.org/10.21564/2225-6555.2016.10.77093

16. Development of algorithms forensic training pharmaceutical seizures from illegal substance as an element of patient protection., Shapovalov V.V. (Jr.), Shapovalova V.A., Shapovalov V.V., Shuvera E.V., European Applied Sciences. – 2013. – Vol. 2, No. 5., pp. 197–199.

17. Legislation in pharmacy, forensic pharmacy and evidence-based pharmacy: Study book (series: Pharmaceutical law)., V.A. Shapovalova, V.V. Shapovalov (Jr.), V.V. Shapovalov, Ju.V. Vasina, V.Yu. Koneva. – [3-rd ed.]. – Kharkiv., 2011. – 160 p.

18. The principles of the pharmaceutical law in solving problems of supplying patients with mental health problems with extemporal medicines., J.V. Vasina, V.V. Shapovalov, V.A. Shapovalova, K.I. Kovalyova., Research result. – ISSN 2313-8955. – 2015. – Vol. 1, No. 1 (3)., pp. 18–29., Medicine and Pharmacy Series., Access mode: http://rr.bsu.edu.ru/images/issue3/medicine/medicine.pdf. https://doi.org/10.18413/2313-8955-2015-1-1-18-29

Литература:

1. Директива 98/26/ЕС «Об определении категорий лекарственных препаратов для человека» от 31.03.1992 г. [Електронний ресурс]., Режим доступу: <http://zakon0.rada.gov.ua/laws/show/z0464-01>.

2. Клевцова Л. Особенности функционирования на рынке препаратов безрецептурного отпуска [Электронный ресурс] / Л. Клевцова // Московские аптеки. – 2003. – № 5 [Электронный ресурс]. – Режим доступа: <http://rudoctor.net/medicine2009/bz-jw/med-kmnaf.htm>.

3. Наказ Міністерства охорони здоров'я України від 17.05.2001 р.

№ 185 «Про затвердження критеріїв визначення категорій відпуску лікарських засобів» [Електронний ресурс]. – Режим доступу: <http://zakon0.rada.gov.ua/laws/show/z0464-01>.

4. Неволина Е.В. Вместо конкуренции – дискриминация: будет две системы отпуска лекарств. / Е.В. Неволина // Московские аптеки. – 2013. – №6 [Электронный ресурс]. – Режим доступа: <http://www.aptekiguild.ru/press?id=204>.

5. Організаційно-правові особливості порядку обігу окремих класифікаційно-правових груп контрольованих лікарських засобів в Україні на засадах фармацевтичного права., В.В. Шаповалов (мол.), Л.О. Комар, В.О. Шаповалова, В.В. Шаповалов // Клінічна фармація, фармакотерапія та медична стандартизація. – 2015. – №1-2 (26-27). – С. 61–68.

6. Постанова Кабінету Міністрів України від 06.05.2000 р. № 770 «Про затвердження переліку наркотичних засобів, психотропних речовин і прекурсорів» [Електронний ресурс]. – Режим доступа: <http://zakon2.rada.gov.ua/laws/show/770-2000-п>.

7. Судебно-фармацевтическая характеристика правонарушений в сфере оборота средств и веществ различных классификационно-правовых групп / В.В. Шаповалов (мл.), В.В. Шаповалов, С.И. Згрожек, В.А. Шаповалова, Л.А. Комар // Фармация Казахстана. – 2015. – №3 (166). – С. 46–50.

8. Судово-фармацевтичне вивчення порушень обігу контрольованих лікарських засобів в закладах охорони здоров'я сільської місцевості / Ю.В. Васіна, В.В. Шаповалов, В.О. Шаповалова, М.О. Хмелевський // Сборник научных трудов SWorld. – Иваново: Маркова АД, 2014. – ISSN 2224-0187. – Т. 30, вып. 3 (36). – С. 59–70.

9. Фармацевтическое и медицинское право: уч. пособ. (серия: Фармацевтическое право) / В.В. Шаповалов, В.В. Шаповалов (мл.), В.А. Шаповалова; под ред. В.В.Шаповалова. – [1-е изд.]. – Х.: Изд-во «Скорпион», 2011. – 208 с.

10. Фармацевтическое право в безопасном самолечении. Лекарственные средства, которые отпускаются без рецепта врача / В.А. Шаповалова, В.В. Шаповалов, Н.Н. Халин и др. – Х.: Скорпион, 2010. – 1200 с.

11. Фармацевтичне право та судова фармація: словник термінів / В.О. Шаповалова, В.В. Шаповалов, О.С. Абросимов, І.К. Сосін, О.Є. Вирва, М.М. Халін, З.С. Галаван, О.В. Данілюк, О.І. Гуторов, О.В. Верещак, Т.В. Кузнецова, С.В. Пасталиця, Г.М. Вишар, Л.О. Гуторова, В.В. Шаповалов, В.В. Бондаренко, В.О. Петренко, О.П. Замошець, Н.Г. Малініна, С.І. Зброжек, В.В. Коляда, С.А. Ященко, А.Г. Якубовська // Фармацевтичне право в системі правовідносин: виробник – лікар – пацієнт – провізор – ліки – контролюючі та правоохоронні органи: Мат. наук.-практ. конф.–Ліки України. – 2005. – №9 (додаток) – С. 213–236.

12. Шаповалов В.В. Введение в медицинское, фармацевтическое право и судебную фармацию / В.В.Шаповалов, В.В.Шаповалов (мл.), В.А. Шаповалова // Право и этика биомедицинской деятельности в России и за рубежом : сб. науч. ст. – Пенза: Изд-во ПГУ, 2014. – ISBN 978-5-94170-857-4. – С. 186–194.

13. Шаповалов В.В. Міжнародна співпраця України з протидії організованій наркозлочинності, наркотрафіку і контрабанді наркотичних засобів на засадах судової фармації та криміналістики [Електронний ресурс] / В.В. Шаповалов // Теорія і практика правознавства. – 2014. – Вип. 1(5). – ISSN 2225-6555. – С. 1–26. – Режим доступу: http://nauka.jur-academy.kharkov.ua/download/el_zbirnik/1.2014/11.5.pdf.

14. Шаповалов В.В. Юридична опіка спеціалістів медицини та фармації в системі правовідносин «лікар – пацієнт – провізор – адвокат – контролюючі та правоохоронні органи»., В.В. Шаповалов., Досудове слідство, фармацевтичне і медичне право, як складові державної політики України у протидії наркозлочинності та поширенню наркоманії: від поліцейської хімії і судової фармації до фармацевтичного і медичного законодавства, соціальної, доказової медицини і фармації: матеріали VIII Міжнар. наук.-практ. конф. (18–19 листопада 2011 р., м. Харків). – Х., 2011. – [Розділ 2]. – С. 246–268.

15. Шаповалов В.В. Судово-фармацевтичне вивчення проблеми зловживання та відпрацювання правових принципів скорочення попиту на психоактивні речовини різних класифікаційно-правових груп / В.В. Шаповалов // Фармацевтичний журнал. – 2014. – № 2. – С. 39–47.

16. Development of algorithms forensic training pharmaceutical seizures from illegal substance as an element of patient protection / Shapovalov V.V. (Jr.), Shapovalova V.A., Shapovalov V.V., Shuvera E.V. // European Applied Sciences. – 2013. – Vol. 2, № 5., P. 197–199.

17. Legislation in pharmacy, forensic pharmacy and evidence-based pharmacy: Study book (series: Pharmaceutical law) / V.A. Shapovalova, V.V. Shapovalov (Jr.), V.V. Shapovalov, Ju.V. Vasina, V.Yu. Koneva. – [3-rd ed.]. – Kharkiv, 2011. – 160 p.

18. The principles of the pharmaceutical law in solving problems of supplying patients with mental health problems with extemporal medicines [Electronic resource] / J.V. Vasina, V.V. Shapovalov, V.A. Shapovalova, K.I. Kovalyova // Research result. – ISSN 2313-8955. – 2015. – Vol. 1, №1 (3). – P. 18–29. – (Medicine and Pharmacy Series). – Access: http://rr.bsu.edu.ru/images/issue3/medicine/medicine.pdf.

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14-19.09

3 stage

RATIO BETWEEN THE ROLES OF AN INDICATOR OF SOCIAL CULTURE, INSTRUMENT OF COMMUNICATION, AND MECHANISM OF PRESERVATION AND TRANSFER OF INFORMATION IN MODERN LANGUAGE SYSTEMS

Philology

10-16.10

3 stage

PHENOMENON OF MASS CULTURE AGAINST THE BACKGROUND OF EXPANSION OF LIBERAL PREREQUISITES FOR DEVELOPMENT OF PERSONAL SELF-EXPRESSION FORMS

Culturology, Physical culture and Sports, Art History / History and Philosophy

10-16.10

3 stage

ORGANIC COMBINATION OF SOCIAL PARTNERSHIP AND INDIVIDUAL IDENTITY AS THE MAIN FACTOR IN ENSURING THE SELF-PRESERVATION AND DEVELOPMENT OF THE SOCIETY

Economics, Jurisprudence and Management / Sociology, Political and Military Sciences

24-31.10

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2017